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## ORIGINAL ARTICLES.

### *A CASE OF PAPULAR ERYTHEMA FOLLOWING VACCINATION.*

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In the simple operation of vaccination it is possible to convey syphilis, leprosy, septicæmia, and perhaps tuberculosis, if due precaution is omitted. But the well-authenticated instances where even so common a disease as syphilis has been conveyed through vaccination are very few. The many evil results which are popularly ascribed to "bad virus" are due either to injury or irritation of the vaccinated part, to the accidental infection of the pustule, or to a personal idiosyncrasy which leads to the development of a rash, such as sometimes follows the ingestion of certain drugs or articles of food.

Irritation of the vaccine vesicle may lead to severe dermatitis, cellulitis, and subsequent ulceration. Infection of the vesicle or pustule by atmospheric germs may induce erysipelas, furunculi, and contagious impetigo, which latter affection may be inoculated elsewhere by means of the finger-nails, and give rise to a pustular or crusted eruption which is very apt to be mistaken for "generalized vaccinia."

The systemic reaction after vaccination may induce eruptions of varying types. These may appear before the development of the vesicle, but are most frequently met with when this is at its height. They may be erythematous, urticarial, purpuric, and even vesicular or bullous in character, but present no specific features which would indicate their vaccinal origin. These eruptions may depend upon some abnormal condition of the patient, in which case the vaccination cannot be regarded as the prime cause of the rash, inasmuch as it merely evokes an eruption which was already latent and which might have appeared spontaneously or from any one of a variety of causes. Frequently, however, the vaccinated subject is in normal health,

and the vaccinal eruption, like a drug rash, can only be attributed to idiosyncrasy.

A not uncommon form of erythematopapular eruption is illustrated in the following case and by the accompanying chromo-lithograph:

In November last I was asked to see a two-year-old child under the care of Dr. Pierson, of Morristown, N. J. The arm presented a well-developed vaccine pustule, drying into a blackish crust (ninth day). Around this were considerable redness and swelling, although there was no indication that the vaccine lesion had been injured or irritated in any way. The face was somewhat swollen, and spotted with a few irregular erythematous patches. The trunk was nearly covered with a bright red erythematopapular eruption, which occasioned the infant considerable distress. The lesions consisted of pin-head-sized, follicular papules, mostly aggregated in small, rounded patches and confluent upon the middle of the back, where the skin appeared red and smooth. The papules were numerous upon the palms, and there were a few upon the soles. Upon the extremities (except near the vaccine pustule) the eruption was by no means as copious as upon the trunk.

The eruption had appeared early in the morning of the preceding day (a week after vaccination), upon the vaccinated arm. In the evening it had developed upon the trunk. After a very restless night the eruption had become quite general, as already described. At this stage the photograph was taken. During this second day of the eruption the patches upon the trunk became smoother and less angry in hue, although they had increased somewhat upon the arms and legs. The skin was still hot and itchy, gentle rubbing of the back proving very grateful to the little sufferer. The temperature marked  $103\frac{1}{2}^{\circ}$ . The treatment consisted in a laxative dose of calomel and the application of a lotion containing oxide of zinc in lime water.

On the following morning the eruption was much smoother and paler. Some of the small discoid patches on the trunk presented a bright peripheral ring, with a dull-red or livid centre. Nearly the whole surface of the child's body was involved by the eruption, and the small areas of normal skin presented a strong contrast with the affected portion. The eruption faded rapidly, and the drying of the vaccine crust proceeded as though no rash had occurred.

**VAGINAL VERSUS ABDOMINAL SECTION  
IN DISEASES OF THE FEMALE  
PELVIC ORGANS.**

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THE rapid evolution of the surgery of the female pelvic organs is one of the great things of this part of our century. Question succeeded question in quick succession until many felt that the end had been reached, and all that remained was the task of perfecting what had been developed. Hardly had we settled down in complacent contemplation of our results with the Trendelenburg posture when we were rudely shaken by this cry of the "vaginal method." Turn from it as often as we may, it yet sings in our ears, and will not be silenced. Intrench ourselves behind a resolution to see in it nothing of good for our patients; view it as a new hobby upon which those of shallow judgment are riding to notoriety, not to honest repute; decry it in all and every way, and it will not down. This is proven by the experience of the past year in this country alone, not to mention what has occurred abroad.

We are to be congratulated that such has been the result of the agitation, for it shows the virility of the subject, and proves that there is a great deal in it for our consideration. As a matter of fact, it is probably the last great question in the surgery of the female pelvis, and deserves to be treated as such by our best men.

Vaginal section has already been injured by exaggerated claims in its behalf. It is folly to talk of driving abdominal section from the field with it, for the reason that conditions will always occur which can be so much better met by the former than no good surgeon would decline to employ it. I think also that the vaginal section will always serve as subordinate to the abdominal, even though it diminish the frequency of the latter one half or two-thirds. This belief is based upon the acknowledgment that abdominal section must sometimes be used to complete the work begun through the vagina. In other words, there are cases supposedly entirely amenable to vaginal section, but which demand, as the operation proceeds, a better operative field, which can only be had by combined section. This single admission shows the interdependence of the methods, and suggests that wherever the boundary between them be drawn it must be made movable; nothing hard and fast can be tolerated.

It is interesting to recall that vaginal section not so long ago held the vantage-ground in this territory, and was driven out except in the case of carcinoma because of its poor results. This was due to its faulty technique in part, and in part to a lack of

familiarity with the actual condition which could be present with a diseased uterus and appendages. Through abdominal section it has now informed itself and perfected its technique, and again comes forward for recognition.

Our attitude in this contention can be best expressed by assuming one hundred as the total of all cases of disease in question now recognized as suitable for section. One year ago I thought this could be divided equally between the vaginal and the abdominal. I now think seventy-five can be assigned to vaginal section, leaving twenty-five to be treated by the abdominal.

As the indications for or against depend largely upon the dimension of the diseased area or growth, one must admit that the earlier the operation is done, the greater the chance for vaginal section. So, assuming that one could observe all cases of uterine and adnexal disease from the outset, it is probable that the ratio would be still further increased in favor of the vaginal route.

Beginning this work at Bellevue Hospital in February, 1892, we have now performed seventy-two vaginal sections, with three deaths, covering every species of disorder for which it has been advocated. This ignores vaginal hysterectomies for carcinoma done in the years prior to 1892, for we wish to eliminate from this discussion as much old timber as possible. What we have to say is based upon our own work; work in no way original, however, although it has not been checked by the observations of others, for we tried to approach the subject with an unbiased mind and aimed at independent work, so that when informed from personal experience we could compare conclusions with contemporaries and with those who had preceded us. It is evident from this statement that we are prepared to modify our conclusions when it can be shown that they are not properly based.

With this understood, we now submit a statement of conditions favorable, on the one hand, to vaginal section, and, on the other, to abdominal section.

*Exploratory incisions.* There are certain obscure conditions of the appendages of the uterus and sigmoid flexure in which exploratory abdominal section has become a recognized operation. Accurate vaginal and rectal bimanual palpation under ether is insufficient to discover enough gross lesions to account for symptoms. Direct palpation or inspection is needed for diagnosis. For instance:

CASE I.—A young married woman, the victim of constant pelvic pain and dysmenorrhoea, came to the writer for operation, having been told by competent authority that nothing short of removal of the ovaries would effect a cure. The pain was referred to the region of the left appendages. Examination without ether revealed what appeared to

be a thickening of the tissue at the base of the left broad ligament, the region being very tender. Under ether the thickening was less marked, but there appeared a sufficient contrast with the same region upon the right to leave the diagnosis in doubt, especially in view of the constant, long-continued complaint of pain. A free incision was made into the cul-de-sac. A careful and thorough palpation of all the structures in the pelvis was made with two fingers, and nothing abnormal could be found. The appendages were drawn into the vagina, and inspection, as well as palpation, showed that they were normal. The patient was up in a week, and, as so often happens after an exploratory incision in such cases, was cured by the operation.

Or take another instance (Case II.). Following curettage and trachelorrhaphy an inflammatory mass developed in the outer upper region of the right broad ligament. Supposing it to be salpingitis plus ovaritis, the cul-de-sac was opened with a view to removal or evacuation. To our surprise tube, ovary, and surrounding peritoneal area were normal. But as the swelling was all the more evident it was carefully palpated with a view to operation. The uterus was drawn down by volsella and two fingers were swept over the entire pelvis. First over the posterior surface of uterus, then the anterior, then along the upper border of the broad ligaments, then down into the paravesical fossæ, thence over the bladder, the anterior pelvic, and lastly the posterior pelvic walls. The following abnormality was in this way mapped out. The outer upper region of the right broad ligament, including its line of connection with the pelvic wall, contained a hard mass; between it and the uterus was a distinct sulcus, in which the tissue, though thickened, appeared in fair condition. To the front, the right paravesical fossa was wellnigh obliterated, the outline of the linea terminalis from the attachment of the broad ligament forward to near the symphysis was obscured all by soft swollen tissue, which evidently was nothing more than a collection of pus connected with and springing from the mass in the broad ligament. We were now at liberty to select an exit for the pus. This could be had in two ways. A direct incision above Poupart's ligament, turning up the peritoneum, reaching the pus about the pectineal eminence. Another route, and the one selected, was directly from the vagina. The cul-de-sac was closed; then, in order to reach the pus and at the same time avoid the ureter, an opening was made as in anterior colpotomy; this was extended beneath the peritoneum, upward and outward to the region of induration, whence the pus thus freely escaped.

*Displacements fixed by adhesions.* From several cases we select one (Case III.) in which the uterus was retroverted, ovaries prolapsed, and both, with

the tubes, were bound down by firm and old adhesions. For two years prior to operation the patient had been subjected to vaginal tamponade for the purpose, as was said, of stretching the adhesions, so as to permit the uterus and appendages to be raised by a pessary. The folly of this policy was never better illustrated, for the organs remained, as they always do, in the abnormal position. Free incision of the cul-de-sac gave easy access to the structures. These were readily stripped of their adhesions, and then by means of Alexander's operation they were permanently placed in proper position. Easy and speedy recovery marked this case.

*Ovarian tumors.* All such tumors small enough to be contained, wholly or in large part, in the pelvic cavity should be removed by vaginal section. Tumors large enough to reach beyond the umbilicus, especially if they are pedunculated and are wholly outside the true pelvis, can be best treated by abdominal section. This observation applies with greatest force to multilocular colloid growths, but even then it is susceptible of modification in favor of vaginal section if it can be shown that both ovaries are hopelessly diseased. Then hysterectomy being permissible, sufficient opening is secured to evacuate properly and withdraw even such colloid growths. If this be true of these latter tumors, it applies with greater force to unilocular cysts with more fluid contents. From this it must appear that while tumors wholly outside the pelvis can be best treated by abdominal section, many of these can be reached by the vagina, provided it be proper to remove the uterus. In these cases it is wise to operate with the hips somewhat raised, else the intestines and omentum will occupy the field, and are apt to cut off the escape of fluid, which then tends to ascend and accumulate just under the abdominal walls.

CASE IV.—An intraligamentous ovarian cyst of the left side, with dimensions about equal to the foetal head at seven months, was removed per vagina through the cul-de-sac. Some difficulty was experienced in enucleating the sac. This was overcome, however, by opening the anterior fornix, through which the sac was easily removed. Our experience in this case impressed us with the advantages of the anterior over the posterior line of approach in the intraligamentous growths. By this route most of them can be removed without entering the peritoneal cavity. After reaching the under surface of the peritoneum in the utero-vesical fold, it is only necessary to push aside the tissue with the finger, when the wall of the sac contiguous to the lateral uterine wall is easily reached and punctured. Subsequent enucleation can then be readily made. By hugging the uterus well up to the region of the body before attempting puncture of the sac, one easily avoids ureter and bladder. Hemorrhage is readily controlled by forceps.



CASE V. *A small pedunculated ovarian cyst (size of fetal head at term).*—The cyst was adherent to the pelvic floor, was therefore readily reached and quickly removed. All such cases are eminently fitted for the infrapubic operation. Solid or fluid, hard or soft, benign or malignant, the route through the cul-de-sac gives easy access and ready control of each and all.

CASE VI. *Extra-uterine pregnancy.*—This was an example of an extra-uterine foetation, in which incision, evacuation, and drainage brought a speedy cure. Bleeding points were many, but they were secured by forceps, which were left in place forty-eight hours. This is a condition which, prior to rupture, one can always elect to reach by the vagina. The tumor from first to last is well down in the posterior regions of the pelvis, and is easily reached through the posterior vaginal wall. It may be necessary to remove the uterus, however, for without this addition we may have excessive hemorrhage. Still, if one can get hold of the connection of the mass by clamping upon its two sides, outer and inner, bleeding can be stopped. After the placenta is fully formed, the child being alive, the suprapubic route would no doubt be preferable. Touching those cases, whether early or late, in which from antecedent rupture or otherwise the foetus is dead, the infrapubic route will meet every requirement, as we have then little more than to evacuate and drain.

*Inflammation and suppurative disease of the appendages, including tubercular disease.* This field is particularly rich in opportunities for vaginal section. In fact, there appears to be no stage which positively contraindicates it. It offers the best means of checking the ravages of acute inflammation, thus tending to the highest kind of conservatism; it affords opportunity for the partial plastic operations upon the adnexæ and uterus, and it gives us the best operation for suppurative disease of these same adnexæ, when their removal is demanded, as in tubercular disease and in the destructive inflammation of both appendages.

It is interesting to note that this class of cases has furnished the battle-ground of this question. But the increasing belief that the uterus must go with the appendages, that hysterectomy in destructive double adnexal disease is required, and, further, that plastic so-called conservative operation upon the uterus and appendages can be done through the vagina bids fair soon to settle the question in favor of vaginal section.

CASE VII. *Acute processes.*—This is an instance of acute salpingitis and pelvic peritonitis following abortion at two and one-half months. The uterus was cleansed and packed with sterilized gauze; the cul-de-sac by a free opening evacuated of turbid serum. The inflamed appendages were not dis-

turbed, a loose gauze drain being carried into the cul-de-sac, which was first washed out with sterilized water. Finally, the vagina was loosely packed with gauze. This was removed at the end of forty-eight hours, the final result being all that could be asked.

This case illustrates what will probably be a common application of one step of the infrapubic operation, namely, the incision into the cul-de-sac with a view to drainage. This step appears to promise much in mitigating the damage which befalls the appendages in the face of the inflammations which come to them through those very common causes—abortions and gonorrhœa. The cleansing of the uterus, together with free drainage from the pelvic peritoneal area, seems to be the rational way of treating such cases, but it is a self-evident proposition that to be of service it must be done early.

CASE VIII. *Acute puerperal metritis, etc.* In connection with the preceding case the present one illustrates the ease with which one may go to extremes when necessary in puerperal septic cases. A woman was septic five days, the form being sapræmia rather than mere sepsis. In ten minutes the uterus was removed and the operation completed. The relaxed and dilated state of the whole genital tract makes the operation exceptionally easy. From this we infer that all such cases are peculiarly fitted for the infrapubic operation.

*Chronic processes.* For illustration, a synopsis of three cases is now given.

CASE I.—By means of *anterior colpotomy* the uterus was anteverted, the fundus and the appendages were brought through into the vagina. The right appendage was normal, the left diseased. The left was removed. The remaining organs were then returned to the peritoneal cavity. The opening in the peritoneum was closed, that in the vaginal wall left open. The uterus was curetted and packed; patient out of bed in a week.

CASE II.—By means of *posterior colpotomy* an adherent and purulent ovary and tube were discovered on the left side. They were removed, a clamp being used. Upon the right side the appendages, being normal, were not removed. The uterus was treated as in Case I. and the patient did quite as well.

CASE III. represented a double ovarian abscess and double pyosalpinx. The pelvis was practically filled with the mass and the associated adhesions. The uterus was first cut out, and then the left and, lastly, the right appendages were removed. The process was tedious, and, owing to the intimate and firm attachment of the rectum, this intestine was torn. No attempt at closure was made, as the opening was small. The recovery was quick, but a fecal fistula remained for two months, when it finally closed spontaneously.



*Fibroid disease of the uterus.* The tumors when of small size are more amenable to vaginal section than almost any other condition. This has already been well brought out at the Obstetrical Society in this city, to whose proceedings I refer for more specific remarks in this direction.

In brief, it may be said that all fibroid tumors lying chiefly in the pelvis are suitable for morcellation by the vagina, the intraligamentous for instance. Pure myomas and fibro-cystic tumors, even though they extend as high as the umbilicus, may also be brought within the limits of vaginal section, but not so with the hard, pure fibroid growths. It is difficult to fix any limit for these, but in general it may be accepted that where such tumors are wholly above the pelvis and fill the hypogastric region they had better be removed by abdominal section. Especially is this the case if the pelvis is narrow and deep; but we find much encouragement to the removal of these growths by the vagina when we contemplate the remarkable work accomplished for so many years in the removal of submucous fibroids by vaginal morcellation.

*Objections.* After all has been said it is plain, however, that there are objections to vaginal section which are sufficient to deter many operators from adopting it. Let us see what they are. The conformation of the pelvis does exercise a decided and, it may be, a controlling influence. All deep, narrow pelvises render vaginal section difficult, and in the case of partial operations, such as removal of but one appendage, when thickness and rigidity of the pelvic floor, as may be met with in some women, is added, will practically forbid it. In the presence of a male pelvis in a stout woman with a narrow vagina one should be slow to adopt vaginal in preference to abdominal section. In this connection I quote from an article already published in the *American Journal of Obstetrics*, vol. xxxi., No. 2, page 5:

"The anatomical condition which presented to me the greatest difficulty was that found in large women with the male pelvis. The deep pelvis with its comparatively narrow outlet was usually found to contain a uterus with unusually thick and inelastic utero-sacral ligaments. I also found in some of these cases a considerable depth of tissue (fat and connective tissue) in the make-up of the pelvic floor. Douglas's cul-de-sac was deep and narrow, and the lateral fossæ of Douglas were wide and roomy. It is in these lateral fossæ that the diseased appendages commonly rest; under the above conditions it was not always easy to reach and enucleate them and then draw them into the vaginal opening. Such a pelvis, however, would offer no special obstacle if the condition demanded hysterectomy, for then the prior removal of the uterus would give easy access to the appendages, no matter where located within the true pelvis. After such removal the opening at command would be almost equal to the confines of the recent pelvic excavation, and through it, as has been shown here, large pus-tubes and ovarian abscesses could be safely removed. Clearly, then, an element of

obstacle in this work is the uterus itself. If the operator planned to remove this organ as a part of his operation, he would have before him no greater procedure than a vaginal hysterectomy, one, too, which was far simpler than the same procedure when executed for carcinoma. A vaginal hysterectomy for cancer generally meant as much encroachment upon tissues and organs about the uterus as was compatible not so much with the integrity of adjacent structure as with the life of the patient. A vaginal hysterectomy for inflammatory disease of the uterus and appendages and for fibroid disease meant, on the contrary, freedom to hug the diseased tissue as closely as possible. In the one, bladder, ureters, and rectum might be in constant danger; in the other they are excluded from the field with the utmost ease. No adventitious guides or guards are needed; such things become, in fact, a hindrance rather than an aid.

"Referring again to partial operations upon the female pelvic organs, such as salpingotomy, oophorectomy, resection of ovaries, excision of pyosalpinx, etc., I find that the thinner the subject and the more shallow and roomy the pelvis the greater the ease of procedure. Another factor likewise exists, as already mentioned, in the make up of the pelvic floor. The thinner this is the easier becomes manipulation."

The claim is made that the operation is liable to be incomplete in the case of pus-sacs. No doubt this is true of the past, and perhaps at the present with some operators, but the youth of the operation accounts for this. The same objections formerly held good with abdominal section in such cases, as is shown by the number of inoperable cases that used to be reported.

Another objection is that viscera are more liable to be injured. This relates chiefly to the rectum, and is no doubt true, but in spite of it the cases do as well ultimately as similar ones done by abdominal section. Such cases when treated by abdominal section require drainage, and prolonged drainage, as a rule. This predisposes to hernia, so that against a temporary vagino-intestinal fistula in vaginal section one must put hernia with abdominal section.

Herniæ are not common after vaginal section, for if they were we would have heard more of them, in view of the long time vaginal hysterectomy for cancer has been a recognized and oft-performed operation. The claim that sepsis is more common is not borne out by the experience of operators. It is true that the average temperature after vaginal section is higher for the first two or three days than after abdominal section, but this applies only to cases in which the forceps instead of ligatures are used.

The same comment applies to the objection urged on the score of the offensive vaginal discharge. Here again the claim rests against the forceps rather than the ligature. But, after all, the objection is one readily controlled by proper vaginal douching, and is relatively an unimportant objection, when the advantages of vaginal section are considered.

*Advantages.* These briefly stated are: As much safety as abdominal section, and this, too, at its in-

ception, leading one to believe that with the same relative time and attention given to it that abdominal section has secured, it will be safer. The recovery is more rapid and the after-condition is better, because herniæ and omental and intestinal adhesions are less common.

at time of operation. The pudenda should be shaved; the vagina and cervix should then be cleansed, green soap and water being thoroughly applied with a brush. This measure must never be omitted, but if one case calls for the brush more than another it is the virgin vagina, the vagina with rugæ. Of course,

FIG. 1.

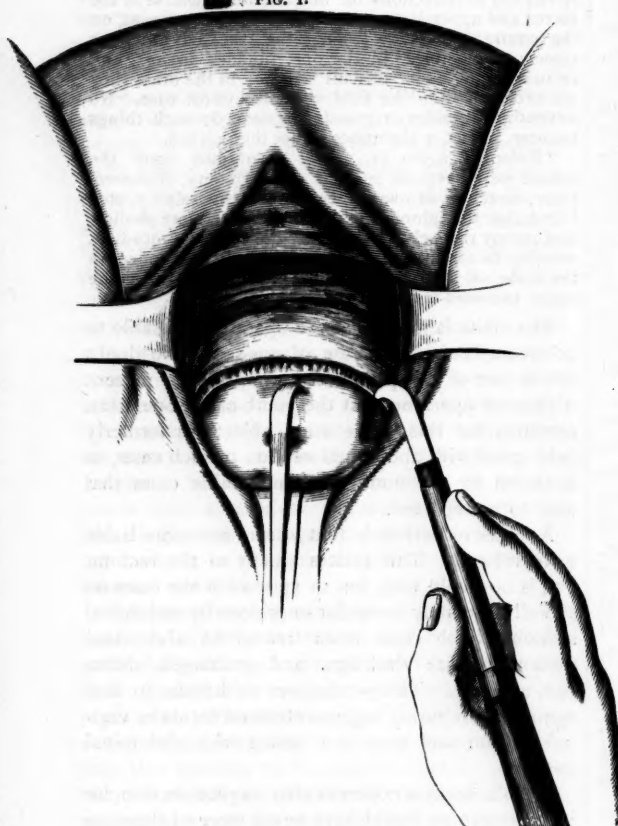


Fig. 1. Vaginal hysterectomy.

FIG. 2.



Fig. 2. Vaginal hysterectomy. Cautery knife in action.

Finally, we beg leave to say that, from all that has been said and done in this subject by the various operators, we might as well admit that a revolution is taking place in our methods of dealing with the uterus and appendages, and it is safe to say that most of the operations done now above the pelvis for conditions specified in this article will soon be done from below. It is merely a question of learning how to do it.

**Operation.** The diet should be light the day before, food being taken as late as six hours prior to operation. Twenty-four hours before the operation a brisk cathartic should be given. Six hours before operation the lower bowel must be thoroughly washed out by a copious enema of castile soap and warm water. The bladder should be carefully emptied

the upper surface of the external genitals, the vulva, the anal regions, and the buttocks must be subjected to the same process of cleansing, the brush being used sparingly on the delicate structures of the clitoris and vestibule. The entire surface, internal and external, must now be washed off with 1:1000 bichloride of mercury solution, and this in turn washed away with warm sterilized water.

When all this has been carefully executed, the patient is ready for any one of the several operations done by the vagina.

If the uterus is to be retained, and is to be curetted and packed, this step is now carried out. The debris of the curettage is then removed by washings of 1:2000 bichloride of mercury, and the patient is ready for the next step. Let us suppose this to be

an operation upon the appendages—some plastic or conservative procedure. In that event the operation is anterior colpotomy.

The body of the cervix is caught with a volsella just below the anterior utero-vaginal junction. Strong traction is then made (Figs. 1 and 2), while with the cautery knife a transverse incision is carried through the vaginal wall from one side to the other about coincident with the above junction. If the uterus is small, this incision need go no further than the sides of the cervix, and by this we mean the line of junction of the anterior and posterior halves of the cervix; but if it is large, it should be extended thence downward and outward half an inch or more, onto and through the latero-posterior vaginal wall. The bladder is next separated from the uterus, using the index and middle finger for this purpose (Fig. 3),

If it be the enucleation of a sub-peritoneal fibroid on the anterior face of the uterus—that is, anterior to the broad ligaments—we proceed to this at once, holding the field of operation against the vaginal incision by pressure from above. If it be the removal, in whole or in part, of an ovary, a tube, or the enucleation of a fibroid at the fundus or on the posterior face of the uterus, posterior to the broad ligaments, we anteverte the uterus and bring the fundus and body through the vaginal incision into the canal (Fig. 4). This can be best done by bringing through first one of the cornua, after which the remainder of the organ is made to follow. Several instruments have been devised to further this step, which is the most difficult in the operation, but nothing is so good as the two fingers of the operator working through the incision, aided, if necessary,

FIG. 3.



Fig. 3. Vaginal hysterectomy. Enucleating with fingers after preliminary cutting of vaginal wall with cautery knife.

FIG. 4.

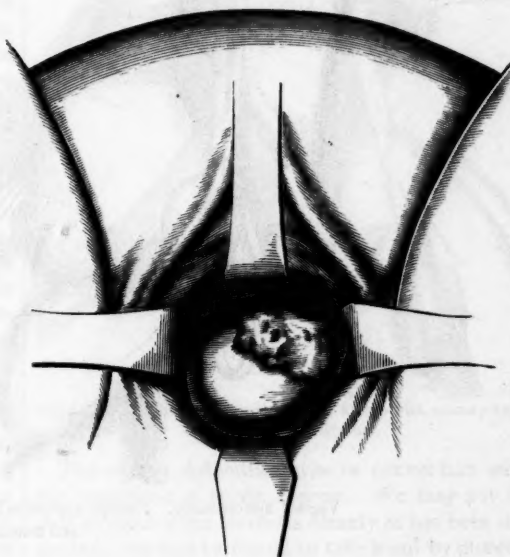


Fig. 4. Anterior colpotomy. Fundus uteri and left ovary drawn into vagina.

and the utero-vesical fossa is entered. Sweeping the fingers right and left, the bladder and ureters are pressed well aside. Still using the two fingers, the several viscera, including uterus, broad ligament and appendages, intestines and bladder are carefully palpated. Finding the conditions favorable to plastic or conservative operations upon the uterus or appendages, we proceed according to the problem presented.

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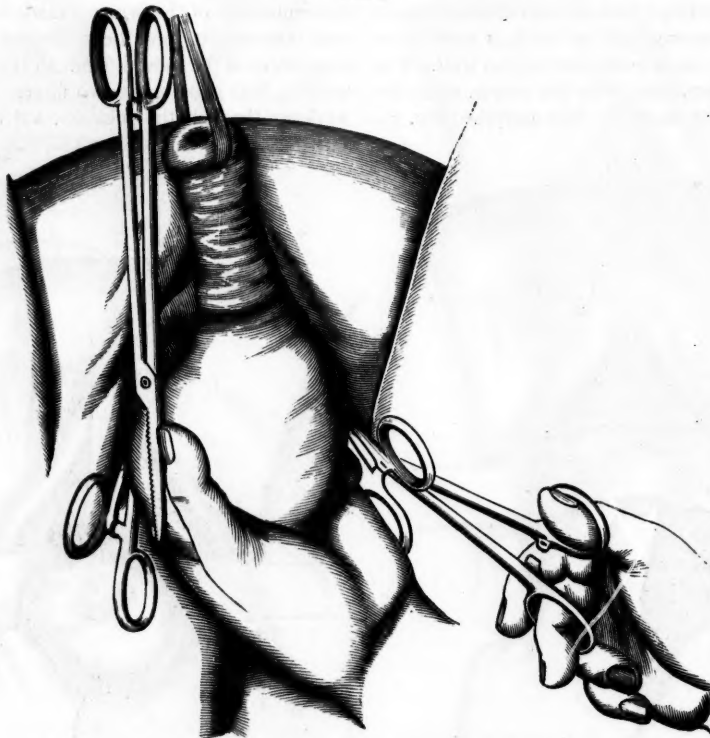
by those of an assistant, placed in the rectum for the purpose of keeping the uterus forward. After the organ is drawn well into the vagina we act in accordance with the problem before us. Fibroids are enucleated upon the same plan as prevails under other circumstances—that is, the capsule is cut through and the growth seized with a volsella, and is worked out of its bed with the aid of the fingers and the scissors. Deep sutures of catgut or fine silk



are then passed, for the double purpose of closing the opening left and checking hemorrhage. If the ovary is to be operated upon or removed, it is drawn through into the vagina (Fig. 4), being reduced in size where necessary by aspiration or incision. When in the vagina it is at the command of the operator, and can be removed in whole or part as need demands. These statements are applicable to the tubes, which should also be brought out into the vagina, being previously emptied of fluid contents by aspiration.

involved bruising of the vesico-vaginal connective tissue, the cut in the vaginal wall may also be closed. If the contrary has been the case, it is best to leave the cut open. It may be sometimes necessary to pass from anterior colpotomy to hysterectomy, as where, for instance, we discover that both tubes are purulent and that the ovaries are similarly involved. This can be easily done by carrying the incision around the entire utero-vaginal junction, and then proceeding to the removal of the uterus, as we shall

FIG. 5.



Vaginal hysterectomy. Forceps applied to lower segment of the right broad ligament and ovarian artery.

The ligation and removal of an ovary (which should be done independently) are, in general, simpler than the same operation upon the tube, because of the more extended blood-supply of the latter. In removing a tube tie as much of the mesosalpinx as you can, this generally is all of it; then ligate the uterine end of the distribution of the ovarian artery by including every structure at the cornu, except the tube; hug this closely with your ligature. Next enucleate the tube, and tie such bleeding points as appear. Having completed the operation, the uterus is returned to the abdominal cavity, and the divided peritoneum of the utero-vesical fold is reunited with catgut suture. If the operation has not

next describe under vaginal hysterectomy, with evacuation and removal of diseased appendages, such as pus-tubes, ovarian tumors, etc.

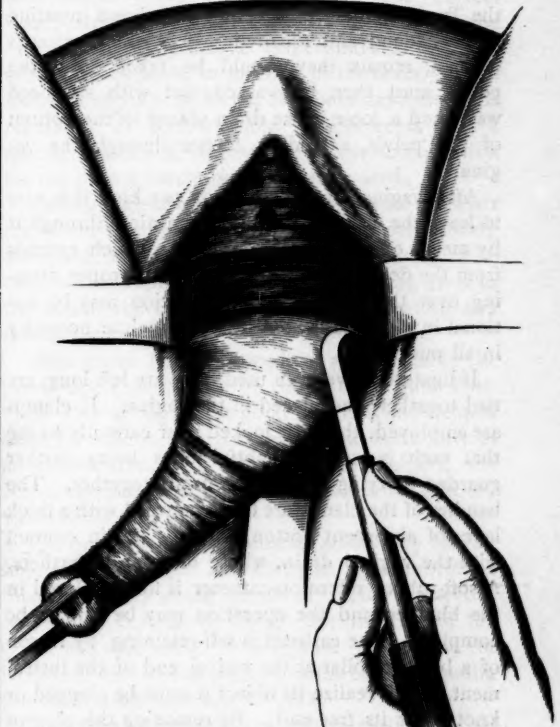
*Posterior colpotomy.* This section is resorted to for purposes of simple drainage, as in acute affections involving the cul-de-sac. It is also a part of the operation which looks only to the evacuation of pus-sacs, the removal of small ovarian tumors, the severing of adhesions, and exploration of the pelvis. It consists of a vertical section of the posterior vaginal wall, extending from the utero-vaginal junction to the bottom of the cul-de-sac. It can be made with knife or scissors, as there is small risk of hemorrhage, and, as a rule, can be closed when the work is done,

unless pus or some such infecting substance as the contents of a dermoid has been encountered.

*Vaginal hysterectomy, with evacuation and removal of diseased appendages, such as pus-tubes, ovarian tumors, etc.* It is assumed that the patient has had the usual preparation, that the bladder and rectum have been emptied. A soft rectal bougie should now be carried into the rectum and passed as far as it can be gotten to remain. The vulva and the vagina having been cleansed, as already described, and the cavity of the uterus, and especially the cervical portion of it, having been curetted and washed out with a solution, 1 : 1000, of bichloride of mercury, the removal of the uterus should be the next step. The cervix is grasped back and front with a blunt volsella and drawn forcibly down as near the vulva as possible. The vagina at the utero-vaginal junction is then cut through entirely around the uterus (Fig. 1). This accomplished, the enucleation of the cervical portion is next in order (Fig. 2), to be followed by measures designed to control hemorrhage. If it be by ligature, this is passed first on one side, then upon the other, so as to secure the uterine artery, which can be easily palpated. If, on the contrary, the clamps be preferred, one is placed on each side, so as to secure the entire lower half of the attachment of the broad ligament to the uterus, which will include the artery. These clamps are made to hug the uterus as closely as possible, and are guided into position by the thumb and index, or index and middle, fingers, thrust one in front and the other behind the broad ligament, at the uterine attachment. The vessels of the lower segment of the uterus being secured by clamp or ligature, the organ is cut free and the enucleation is carried on with the index and middle fingers (Fig. 3) until the bladder is separated and the utero-vesical space in front and the cul-de-sac behind have been opened into; the vessels at the sides are not molested, the vaginal wall being merely pressed back to give easy access to them when ligatures or clamps are to be applied. If the case is simple, that is, if there is no extensive matting together of the viscera, as in bad cases of suppurative disease, the peritoneum upon the base of the bladder and in the cul-de-sac should be attached with a single stitch (catgut) to the corresponding vaginal wall. The way is then clear for the application of the clamp or ligature, as one may elect, to about its middle, still applying steady traction; the upper attachment of the uterus is next brought down; this is clamped (Fig. 5) or ligated, after the manner already described, and then the entire uterus is cut out. The succeeding steps depend upon the condition presented. If it be a simple pyo- or hydrosalpinx, these, along with the degenerated ovaries, are enucleated by the

fingers, aided by long forceps, and are then clamped or ligated at the attachment to the broad ligament and cut away. If it be an ovarian tumor, this is drawn down to the cut in the vaginal roof, is there tapped, and after the contents have been removed the sac is withdrawn much after the manner which prevails with abdominal section.

FIG. 6.



Vaginal hysterectomy. Enucleation of uterus with cauterizing knife without clamp or ligature.

The serious difficulties arise in connection with the conditions of pelvic abscess. We may not be able to remove the uterus as cleanly as has been described, but may be forced to take it out by morcellation. Cut it out segment by segment, clamping the bleeding vessels as they appear. The posterior lower half is first removed, then the anterior. In this procedure we may open promptly into a pus-sac in the cul-de-sac. After cleansing this out, we proceed to the upper half of the uterus. This should be cut open antero-posteriorly. After removing the two segments, we use the cut ends of the cornua as guides to the pus-sacs, tubes, and ovaries of either side. Feeling one's way carefully, making traction upon the sacs, which by this time can be differentiated, first one side then the other is drawn down, enucleated, and withdrawn. It may be that this process of enucleation will have to be

done in the depths of the pelvis; if so, one cannot use too much caution, for it is in such cases that visceral injuries are most liable to occur. Patience and intelligent perseverance will enable one to surmount the difficulties, however, so it is rare that one will be forced to call to his aid abdominal section. This, however, should be done if the intestines high up in the pelvis have been injured. Having opened above the pubis, the patient should be thrown into the Trendelenburg posture and the injured intestine quickly found and repaired. If any sacs, or parts of sacs, remain they should be taken out; the pelvis must then be washed out with sterilized water and a loose gauze drain placed in the bottom of the pelvis, extending thence through the vagina.

After vaginal hysterectomy of any kind it is wise to leave the vaginal cut open, draining through it by means of a good strip of gauze, which extends from the depths of the cul-de-sac to a proper dressing over the vulva. This precaution may be optional in clean cases, but it is an absolute necessity in all pus-cases.

If ligatures have been used, they are left long, are tied together, and placed in the vagina. If clamps are employed, they are looked over carefully to see that each is secure, doubtful ones being further guarded by tying the handles firmly together. The handles of the clamps are then encircled with a thick layer of absorbent cotton, which is also in contact with the vaginal drain, whose function it furthers. A soft-rubber retention-catheter is finally placed in the bladder, and the operation may be said to be complete. The catheter is self-retaining, by reason of a bulb or collar at the vesical end of the instrument, but to realize its object it must be plugged or knotted at its free end. By removing this plug or knot at intervals of two or three hours the bladder is properly emptied and the dressings are kept clean. This upper cotton dressing and the catheter are the same for all cases of vaginal section.

This article would not be complete were we to omit mention of the method of removing fibroids by morcellation.

The preliminaries up to and including separating the vagina from the cervix are identical with the process already described. The departure begins after the cervix has been enucleated, and the lower vessels ligated or clamped. This consists in cutting away, piece by piece, first the cervix, then the body of the uterus, dragging each piece forcibly downward with blunt-toothed volsella; bleeding points are caught as they appear and ligated or left in the keeping of the clamps, as convenience dictates. Working after this fashion, with knife and scissors, protecting the vaginal walls with retractors, the tumor is dragged piece by piece into the vagina, and then

cut off. In this way the operation is really performed within the vagina, sparing the cavity above it. As already intimated, the dressing and later treatment of the case coincide with those adopted in other vaginal sections.

A word must now be said about enucleation without clamps or ligature. It can be done, but it has its limitations, and should be performed with the cautery. We confess that a ligated or clamped vessel makes us less anxious, and as there is no valid objection which is at all weighty, we prefer to use one or the other.

The best cases for this operation are women past the menopause or who have already been rid of their appendages—the uterine vessels being with all such persons more or less atrophied.

It is done as follows (Fig. 6): After the usual preparation, seize the uterus at the cervix and burn through the vagina at the utero-vaginal junction. Now keep up forcible and continuous traction upon the cervix, at the same time burning through the attachments to the uterus as they descend. This burning must be made within the true uterine tissue rather, the cautery being driven firmly into it. It is best after each segment has been burned through to relax the traction, to see if the vessels just severed bleed; if they do, sear them at once, and continue it until they are closed. Proceeding in this manner the uterus is quickly peeled from its envelope, and the cornua are brought into view. These are burned through and their stumps seared. In the removal of the tube and ovary it is wiser to use ligatures or clamps. This having been done, the operation is complete. The after-dressing and treatment are the same.

Speaking now of vaginal hysterectomy in general, clamps should be removed in from forty-eight to seventy-two hours, after which the patient should receive a night and morning douche of warm boric acid or permanganate of potash solution, for purposes of cleanliness and comfort. Ten days cover the usual limit of convalescence in bed, the patient being permitted, under ordinary circumstances, to take the sitting position in bed at the end of a week. The catheter should be removed when the clamps are taken off. Ligatures should be cut out at the end of two or three weeks. The bowels are treated much as in abdominal section, but there is one comfort the patients with vaginal section can enjoy, that is, morphine for the relief of pain. This drug does not appear to have as troublesome consequences after this form of operation as after abdominal section. With this, Mr. President, I must close.

Recapitulation of conditions favorable on the one hand to vaginal section, on the other to abdominal section in diseases of the female pelvic organs:



*Vaginal Section.*

1. A shallow and wide pelvis in a thin woman.
2. Explorations of the pelvis.
3. Visceral adhesions in true pelvis.
4. Displaced and adherent uterus.
5. Smaller ovarian cysts, especially the intraligamentous and parovarian.
6. Smaller fibroids, especially the soft.
7. Extra-uterine pregnancy, up to seventh month, and after death of fetus.
8. Pelvic hæmatocele.
9. Puerperal hysterectomy.
10. Acute inflammation of appendages, with peritonitis involving cul-de-sac.
11. Inflammatory destructive diseases of the appendages, including tubercular disease.
12. Pelvic abscess pointing downward.
13. Conservative operations on appendages that lie in true pelvis.

*Abdominal Section.*

1. A narrow and deep pelvis, especially if deformed.
2. Explorations above the true pelvis.
3. Visceral adhesions in false pelvis or above.
4. Large ovarian cysts, especially multilocular, with colloid contents.
5. Large fibroids, especially the firm and hard.
6. Extra-uterine pregnancy at time of rupture and at term.
7. Extra uterine pregnancy, with tumor wholly above brim of pelvis, and not in relation with uterus.
8. Pelvic abscess pointing upward.
9. Conservative operations under conditions unfavorable to vaginal section, such as a narrow and deep, or a deformed pelvis, that is contracted.

**THE THERAPEUSIS OF THE SAINTS.**

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THE modern instances of the belief in simple faith or superstitious worship in the cure of disease, as exemplified in the almost daily reports of marvellous recoveries attributed to the efforts of "faith-curists," "mind-healers," "layers-on-of-hands," and the like, furnish this century's analogue of the ancient custom of invoking the aid of the saints in the relief of the afflicted.

Superstition, Paul Lacroix has said, is the inevitable consequence of every religion or Deism, and to the simple, ignorant mind it naturally becomes more powerful than the religion itself, being more awe-inspiring and impressive. In the history of all nations and peoples the superstitious belief in the efficacy of deified personages in alleviating pathological lesions has prevailed.

In the ancient Pagan times the divinities were the precursors and parents of pathology—the old gods are dead, but the heavens and the maladies still retain their intimate relations. The patrons, once placed in Olympia, were transferred to Para-

dise. In the heaven of the old Pagans there were supposed to be lodged a long succession of gods and goddesses, whose province was to look over the diverse maladies of humanity. The material sheath of our soul, with its miseries external and internal, was supposed to be carefully guarded by this collection of deities.

The matrons contemporary with Augustus Cæsar well knew whom to address for the correct manipulations and treatments of childbirth. In the first instance they prayed to Pertunda to facilitate advantageous union or meeting of the sexes. Then followed appeals to Mena, on whom depended the regularity of menstruation. Materprema had a special mission in keeping the uterus in condition for the proper reception of the male seed.

Having carefully and successfully pursued their respective functions up to date, these deities were dismissed, and, conception happily ensuing, Flunia was summoned to care for the growing germ in the womb, and keep out the evils of abortion and miscarriage.

Then grand Diana stepped in, and looked to the preservation of the life of the fetus. Juno Post-versa labored to put it in good position, and stepped aside for Lucina, who was famous for her ability as an obstetrician, and with her little helpers, the Nixii, who pushed hard for the contractions, effected a safe delivery.

The members of the Celestial aristocracy having successfully brought the child to light continued their monopoly in the person of Jupiter Diespiter, or possibly Cunina, to whose care the life of the child was entrusted. Throughout the period of lactation, with mystic passes over the breast, Rumilia produced a sufficient flow of milk.

Turning now to the more enlightened Christian woman of the latter period, we find her still happy in the protection of the plethoric heaven of sanctified personages, but to a less degree than her Pagan sisters. With the advent of Christianity, Saint Agatha replaced Rumilia in exercising an influence, for good or bad, as the case might be, over the female mammæ. Invocations to her were deemed the best means of relief from mammitis. The older Christian woman addressed her prayers to Notre-Dame-de-Montserrat, Saint Marguerite, and worshipped at Lourdes and at the statue of Saint Guignolet. The latter will soon be a thing of the past, if its original does not acquire a better degree of proficiency, as it is fast disappearing under the scratches of sterile husbands.

Happily, if parturition is seemingly neglected by the saints, the pathological disturbances of the human body are plentifully supplied with patrons and patronesses from this overworked society, each of whom has a designation, either curative or causative, in some disease. Saint Guy had under his

domination the neurosis, chorea, often called "danse de Saint Guy," or St. Vitus' dance. Formerly they danced before the chapel of this saint to be relieved; but since the discovery of the efficacy of arsenic Saint Guy is neglected, and the neurologist has usurped his domain. Saint Giles struggled with the hopeless task of carcinoma, besides lending adjunctory assistance to the others in the obstinate cases of epilepsy. Saint Gervasius gave many a sharp reminder to the unfortunate under his care, and has to-day a deadly rival in the lithiates and salicylates. His rheumatic clients are rapidly forsaking him, and, in fact, his memory is only perpetuated by an occasional charm or amulet among the lower classes. Saint Genou is fortunate in the possession of two helpers in the cure of gout, viz.: Saint Mor and Saint Gueslain. Coquillart bears witness to the efficacy of the former in his *Monologues des perrecques*, in which is seen "I come to Saint Mor des Forrez to be relieved of the gout." Homage is rendered to both these auxiliary saints in the old comedy, "Pasté et de la tarte," in which a character cries out,

"Que la goutte  
De Saint Mor et de Saint Gueslain  
Vous puyssiez tresbucher a plein."

In cases of toothache, each jumping pain was considered the individual handiwork of Saint Apollonia, and to her the victims of this distressing minor ill looked for relief. Our *confrères*, the dentists, have played sad havoc with this saintly lady, and, like Othello, "her occupation's gone."

By his good offices Saint Main saved the itching commoner from scratching. If we can correctly judge from a passage in Ambrose Paré (des Venins), this same individual brought succor to individuals afflicted with dermal manifestations of syphilis. Paré says: "An ointment of quicksilver cures what is called commonly the malady of Saint Main;" and, after a glance through the *Commentaires sur Dioscoride* of Antoine du Pinét, we are lead to believe that this saint looked after other cutaneous eruptions such as tetter, eczema, milk rash, etc.

Saint Reine was a valuable constituent of this sanctified system of therapeusis, curing thrush and scald-head. Having recovered from a severe and terrible fever, this Saint went to church to give thanks for his recovery. Jesus was duly thanked, but, turning to a picture portraying Saint Anthony with a white beard, he said: "Y no a vos, barba blanca, que tan mal su fuego me trato, y me quemó en mis calenturas." This warrior was not willing to thank Saint Anthony with his white beard for the fire that had almost consumed him during his fever.

Saint Avertin, Saint Romain, Saint Gildas, and

Saint Mathelin divided among themselves the various forms of mental aberration. In the very early days Gheel seems to have been a kind of Lourdes, for, according to the *Cornhill Magazine*, a certain St. Dymphna, who lies buried there, was supposed to have *les faibles d'esprit* under her special protection. It was the custom, therefore, throughout the Netherlands for persons who had insane relatives to take them to her tomb and there offer special prayers to her for their recovery. If tradition is to be relied upon, the saint was by no means loath to give proof of her beneficent power, and wonderful stories are told of the way in which she used to restore reason to those who had lost it. Still, even in those times miracles were not wrought every day. Some of the sufferers who went to Gheel had to wait for months—nay, years—before they were healed, while others were never healed at all. And while waiting they had to be taken care of. At first the innocents, as St. Dymphna's *protégés* were called, were all lodged in little huts or caves around the church, but as the fame of Gheel spread abroad they increased in number, and it became necessary to make other arrangements. They were then boarded out with the peasants living in the village, and there were so many of them that at length every family had its innocent. If a child was constantly crying and fretful, says Panckoucke, in his *Dictionnaire des Proverbes*, he was committed to the care of Saint Avertin. In his *Harangue de Midas*, Bruscambille writes: "There is no receipt compounded by any doctor or apothecary, no matter how wise, which is potent in the malady of Saint Avertin."

Saint Eutrope was supposed to cure hydrops, as we can see in the nouvelle cxxix of Bonaventure des Periers; but the invocations to this patron were in vain in the celebrated case of Louis XI. If M. Chéreau is well informed, Saint Eutrope (eau trop) is but one of that series of saints whose province originated solely from a quibble or witticism on their name. Eugène Noël advanced this theory, and gives a few examples. Saint Genou, who was the solace of those afflicted with rheumatic or gouty joints, was probably one of the number; Saint Mammard (mammelle) ripened the abscesses of the breast; Saint Marcou (mal au cou) was supposed to have the power of effacing scrofulous marks and curing the King's evil; and Saint Fiacre carried solace to those unfortunate enough to suffer from affections about the anus—particularly vegetations—from the resemblance of Fiacre to "fic."

F. Brémond says the hypothesis of Noël becomes an absolute certainty in the case of the patron of the inhabitants of Lourcine and the Hospital du Midi, and quotes the interpretation of the name of this saint as given by his master Jacob. "The recoveries are divided between the saints, who take

the monopoly of cure to themselves, and sometimes a saint has been invented expressly for the malady, as, for example, when the venereal malady first made its appearance there was soon found, where no one knows, a Saint Foutin to take the pox-stricken sufferers under his auspices."

From the North to the South, the saint most respected in sacred therapeutics is Saint Hubert. The number of individuals that he is reported to have cured of the "rage," or hydrophobia, is incalculable. He was given, it is true, the assistance of Saint Mathurin, but what help is he to the great patron of the chase, whose name is as familiar to the smooth chin as to the white beard, and we dispense with details, for this great patron had a glory which admits of no addition.

In the middle ages Saint Lazare was the busiest of all. In our times he is virtually in a lethargy of idleness. It is true that we continue to call some of the sanitary stations "Lazaret," but these are nearly always empty, and when they contain a patient his malady is far different from those of olden times. Saint Lazare was the guardian of the leprous, more commonly called in France "ladres" or "mesels." In the 18th century, in France alone, there were more than two thousand hospitals for lepers. To-day, thanks to science, the universal vanquisher of cant, hypocrisy, and superstition, a case of leprosy is cause for excitement and discussion in all the journals and among those versed in this pathological rarity.

Saint Sebastian was invoked for the "peste venenosque," and had for his assistant Saint Roch. In *les Aventures du Baron de Foënesté*, d'Aubigné shows a Gascon who had fallen into the charnel-house of the plague-stricken, and employs his priest to say a mass to Saint Roch. Like this Gascon, the pious inhabitants of a certain village in Provence, even to the 19th century, cry once a year "miséricorde" in the chapel of Saint Sebastian. In the south of France Saint Hermantaire is still supposed to look after children who are timorous, nervous, or who are subject to convulsions, and Saint Victor calms their fever. If one consults him, devout inhabitants of Marseilles will tell you that, after the Virgin Mary, no one possesses the power of more miracles than Saint Victor.

Saint Gerbold was much occupied with dysentery, while Saint Regnauld was not indifferent to those suffering with affections of the bladder. In all cases of colicky pains, whether from excesses in eating or otherwise, supplications were addressed to Saint Erasmus. To the bibulous was given a patron in the person of good Saint Martin. Needless to say, few candles were burned for him, as curing the evil in this instance was worse misfortune than its continued existence.

If we consult Henry Estienne's *Apologie pour*

*Herodoté*, in the preface of his edition of that great historian's work, we find that the curious duty of Saint Bernardin was to keep a guardian eye over the "suffocations of the matrix." If one should be asphyxiated, for relief he would invoke the aid of Saint Eloi.

The last alphabetically of this long list of pathological patrons was Saint Zachary, who cared for the dumb.

Félix Brémont, who was called to account by a friend for his campaign against superstition, and was accused of citing the customs of olden times with the present day in his arguments, denied the anachronism, and, among others, quoted from page 198 of *Pèlerinage de Saint Hubert*, by Abbé Bertrand, printed in Paris, 1869, the following: "In order to prevent the 'rage' they carry devoutly on them objects blessed or which have touched the miraculous stole of Saint Hubert, such as crosses, rings, chaplets, etc." M. Brémont also produced modern books in which were a prayer to Saint Christopher to keep off sudden death; an oraison to Saint Vite for defence against the rage of ferocious animals; an invocation to Saint Blaise for the cure of sore throat, and a pious invocation to Saint Magnus for protection against venomous insects. M. Brémont, in addition, promised his friend a copy of Paul Parfait's *Arsenal de la dévotion*, in which he could revel in superstition to his heart's content. M. Brémont, on reading that the Queen of Spain was expecting her confinement, and had been provided with a bone of Saint John the Baptist, the comb of the Virgin Mary, containing three of her hairs; a chemiset of N. S. Jesus Christ, together with a reserve relic in case the foetus would exhibit signs of recalcitrant royalty, the body of blessed Diégo de Alcala, suggested in his piquant, skeptical French manner, as a grand completion to this arsenal of saintly obstetrical aids, the following:

1. A wax taper from Notre-Dame-de-Montserrat, which the reverend Pierre de Bourdeilles, Lord of Brantôme, declares, in his fourth chapter of *Des dames galantes*, a strong aid to the Spanish ladies in childbirth.

2. The reliques of Saint Marguerite, which served Marie de Médicis so well, as told in the works of the celebrated midwife, Louise Bourgeois. But despite the assistance of the relics and the incessant prayers at Saint-Germain-des-Prés, she lay in agony 22 hours.

3. A piece of the robe of Saint Ignace, which R. P. Terwecoren says is equally efficacious to the mother fearing pregnancy, and the female who trembles lest the soft name of mother will never greet her ear.

4. An agnus of white wax coming from the Chapelle Sixtine, which the Canon Barbier de



Montault remarks protects both mother and child during pregnancy and deliverance, and shortens and ameliorates the throes of labor.

5. A cordon of blue wool from Saint Joseph to expedite matters; for, says R. P. Huguet, "what is impossible for the doctors is easy for Saint Joseph."

6. The oraison of Sainte-Croix discovered in 1550, and reprinted in 1880, in Paris, in which are these words: "When a female finds herself in pregnancy, she is expected to read or repeat this prayer, or to carry it on her, and she will be expeditiously delivered; she will remain a tender mother, and when the infant is born, if the prayer is placed on its right side, it will be preserved from a great number of accidents." After generously offering these suggestions to the royal Christine, M. Brémont adds:

7. *A pair of forceps.* It happens sometimes that this instrument is not unuseful in accouchements, even of royalty. In the case of another Spanish woman of the royal blood, Eugénie de Montijo, in spite of a strong armament of saints' bones collected by herself and her august spouse, the "fers de l'accoucher" sensibly flattened the ears of the youthful scion, who was called by Cassagnac "Napoleon IV.," and who eventually offered up his life to the British Government in the war with idolaters in Africa.

To complete the list of the virtues and powers ascribed to the saints would take this short sketch too far. At first glance, many of these facts seem exaggerated and almost incredible; but when we have before us in our own day the much-vaunted powers of the waters of Lourdes, with their enormous patronage, drawn from the high as well as the low classes, and from every section of the world; the almost daily pilgrimages to other famous wells and shrines; the custom, still extant, of the exposition of saintly relics for therapeutic purposes; the frequent account of faith-cures in this country as well as in the old, we can readily believe that the world is by no means lifted from its superstitious ignorance by the rapid advances of pathology, and, strange to say, the very countries that have done most to advance science are the most tenacious in their old medieval fears and faiths.

## CLINICAL MEMORANDA.

### EXTENSIVE LACERATION OF THE ABDOMINAL WALL BY A BULL'S HORN; EXTRUSION OF THE INTESTINES; OPERATION; RECOVERY.

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J. D., male, aged fifty years, a strong, healthy farmer, weighing about 180 pounds, was gored by a bull at 9 A.M., July 21, 1893. As the animal rushed at and lifted him,

one horn penetrated the left trouser-leg six inches below the groin, scraped the skin along the thigh upward until it struck the protruding abdomen one inch above Poupart's ligament and just outside the internal abdominal ring, where it penetrated the peritoneal cavity and ripped the abdominal wall obliquely for five inches from this point in the direction of the free end of the twelfth rib of the left side. The laceration in the skin was less extensive than in the muscular layers, although the integument was dissected or torn loose from its subcutaneous attachment for four or five inches in all directions from the upper margin of the wound. The other horn struck the patient just below the left axilla, tearing an ugly gash in the axillary space, dividing some of the vessels of the pectoral region, but, fortunately, not wounding the larger vein, artery, or nerves. In descending, the patient fell on the back of the animal, rolled to the ground, and scrambled to his feet. As he stood up he felt his intestines rush out into his clothes, and then fell unconscious. He was carried to the house, put to bed, and Drs. Card and Owen, of Mahopac, summoned.

I saw this patient at 6 P.M., nine hours after the accident. As it was getting late, every haste was made for operation. Chloroform was used. A large mass of small intestine, congested but not strangulated, dotted here and there with hair, shreds of clothing, and several bruised and dark spots, varying in diameter from one-fourth to one-half inch, protruded through the opening in the skin. A finger carried into this opening recognized a second and equally large mass of intestine lodged in a pocket between the muscles and the loosened integument. The opening through the skin was freely enlarged in order to expose the entire mass, which was now irrigated with hot boric acid solution (gr. viij to 3j of water, boiled and allowed to cool to about 110° F.). A finger carried through the lower angle of the laceration in the muscular wall satisfied me that there was no intraperitoneal rupture with escape of intestinal contents. A mass of omentum, covered with clot and hairs, was tied off with catgut sutures, and the stump was later returned to the peritoneal cavity. Commencing at this angle of the wound a careful toilet of the intestine was made, after the entire mass had been irrigated as described above. Hot towels enveloped the coils above. Section after section of six inches each of gut was isolated and washed with soft, small sponges, wet in hot boric acid solution and squeezed nearly dry. The mesentery, from the deepest portion of the wound, was exposed and cleansed on both surfaces up to the intestine, and then this was gone over and returned to the peritoneal cavity. This process was repeated as rapidly as was consistent with thorough cleanliness until the entire length, estimated at fifteen feet, was reduced. The ragged edges of the torn muscles were trimmed where long shreds were hanging, a twist of iodoform-gauze was carried into the peritoneal cavity and out at the lower angle of the wound for safety drainage, in case of infection, and the wound closed by a single row of silk sutures passing through skin, muscles, fascia, and peritoneum, with tight approximation of the edges, except at the drain, where a single suture was only fairly tightened. The time consumed was one hour and forty minutes.

On the fourth day the temperature of the patient, which up to this time had not been over 100° F., reached 102° F., and there was considerable pain in the wound

at its lower portion. The twist of gauze was removed, and about half an ounce of odorless pus escaped. A smaller twist was reinserted, and this was removed daily for three or four days, when the discharge ceased. Nothing of interest occurred after this, and the patient recovered.

At this time, more than two years after the operation, the man is well. There is a small ventral hernia at the lower angle where the gauze drain emerged, the scar protrudes perceptibly, and, on coughing, a localized impulse is evident.

In analyzing this case some points of interest are suggested.

What should be the immediate management of cases where the intestines protrude?

(a) The arrest of hemorrhage is, of course, an immediate and vital necessity, but, fortunately, it is seldom a dangerous complication. The extrusion of the intestine takes place rapidly, and usually is so extensive that the large mass of omentum, mesentery, and gut arrests ordinary bleeding by self-compression at the opening in the abdominal wall. When bleeding occurs it should be controlled by catgut ligature or warm towel or gauze compresses.

(b) It is always advisable to restore the viscera to the peritoneal cavity as soon as possible. If, for any reason, this is not undertaken, the protruding organs should be kept warm and moist by being enveloped with towels or napkins, wet and kept moist with hot bichloride solution 1:10,000, or boiled water cooled down to 110°-120° F. The solution should not be carelessly employed, for, though absorption is limited from the exposed surfaces, a considerable quantity may leak into the general cavity of the peritoneum, with harmful result. Complete anesthesia is essential when reduction is undertaken. For the final toilet of the soiled viscera I prefer the boric acid solution, but have also employed the 1:10,000 bichloride solution with good effect.

(c) The method of suturing wounds through the abdominal wall is of great importance. I am convinced that fewer ventral herniæ occur after the suture heretofore described than by any other method. Moreover, it occupies much less time than when a separate peritoneal suture and one or two muscular and cutaneous rows of suture are inserted.

(d) In all instances where a considerable mass of intestine has been exposed and is soiled, no matter how careful the toilet, it is advisable to insert a twist of iodoform-gauze for safety drainage. This precaution saved the subject of this report. It is usually removed on the third or fourth day, the sutures on the eighth or ninth day.

(e) In order to prevent adhesions between the exposed and inflamed coils of intestine and to forestall intestinal paresis, which occurs with peritonitis, this patient was given saline laxatives twice a day, commencing on the morning after the operation, and securing two or three movements a day for four or five days. Epsom salts and Hunyadi water were employed. Calomel triturations, gr. j-ij, at night are safe and effective. The minimum of morphine should be administered, and none at all if it can be dispensed with.

(f) After an extensive wound or incision in the abdominal wall a patient should not be permitted to bring any considerable strain upon the part involved until

thorough union has been secured. I usually require six weeks in bed or about the room, and the recumbent posture for at least four weeks.

(g) An accident occurred during the operation which came near proving fatal. But for a precaution which should invariably be practised, and prompt action by all engaged, the patient would have perished on the table. On account of pain and shock, the attending physician had administered morphine in considerable quantity. This so dulled the respiratory sense that during the operation, and just as the last loop of intestine had been restored, although a very small quantity of chloroform had been used, the patient ceased to breathe, became almost instantly cyanotic, with jaws tightly clinched. With special forceps, pointed so as to take advantage of the slightest space or unevenness between the upper and lower rows of teeth, the under jaw was pried open, the tongue seized and drawn out, and artificial respiration by Sylvester's method performed. After several minutes of anxiety (at least five minutes, by common estimate of the five physicians present) the natural respiratory effort returned, and the operation was finished without further narcosis. I have in a number of instances seen death from arrest of respiration prevented by this precaution, without which, it seems to me, an anæsthetic should never be given. A wooden screw or wedge for separating the jaws, and a strong fixation gag, and forceps for holding them fast, a fixation forceps for the tongue, and sponges on holders are the essentials.

#### URETHRAL HEMORRHAGE; HÆMOPHILIA.

BY CAPTAIN A. E. BRADLEY, M.D.,

CAPTAIN AND ASSISTANT SURGEON, U. S. ARMY, FORT YELLOWSTONE, WYOMING.

MR. L., after an alarming hemorrhage during the night, asked me to see him the following morning; the history obtained was this:

Occupation, merchant; aged thirty-three years; unmarried; parents and other members of family all in good health. About a year ago was treated for some time in a Chicago hospital for some obscure bladder trouble, probably cystitis. Since that time he has used occasional boric acid irrigations, and passed a sound monthly. Because of the cystitis he has been carefully observing his urine for sediment.

Two days prior to his present trouble he noticed a marked deposit in the bottle, which he described so as to lead me first to believe was pus, but later he said the urine was perfectly clear when voided and the sediment only appeared after standing some hours. It being a cold night, it may have been granular or amorphous urates; of this I cannot be certain. Microscopic examination showed no pus in the specimens afterward obtained. For some days he had had some vague discomfort referred to the right abdomen, but no pain. His habits are temperate, and he has not had sexual intercourse since July of the present year. His sexual desire, however, has been strong, and he has been troubled with frequent annoying erections both night and day. On the day preceding my visit he had been standing nearly all day bending over a low table working at photography; he remembers his erections were troublesome, but is not certain that he injured himself in any way.

About seven in the evening, and about one hour after passing normal urine, without any warning, his attention was called to a warm trickling down his thigh.

Investigation showed blood spurting from his penis in alarming quantities. It could be controlled only by grasping the organ tightly in the hand, release of the constriction being at once followed by the hemorrhage. A large bath-towel was saturated and the carpet showed two spots covered with clotted blood, not smaller than dinner plates. He believes he lost more than a pint of blood, and I think this is a small estimate.

He was much exhausted, and went to bed, though he slept but little, having occasional erections which renewed the hemorrhage. In the early morning he passed clear urine, which scalded one portion of his urethra and was followed by slight bleeding. He "milked" a clot from his urethra, which brought on hemorrhage again.

At noon he passed normal urine in my presence with no scalding, and but a slight trace of blood followed his milking process. He rapidly recovered his usual health.

I regret that I was unable to make an endoscopic examination. There was no infiltration into the tissues of the penis, and no pain except at one point near the scrotal junction, where there was slight tenderness, probably the source of the trouble. His abdominal uneasiness and the other symptoms first led me to think of renal trouble, which may indeed exist, but the hemorrhage was undoubtedly urethral.

Since childhood he has noticed a tendency to bleed profusely after slight injuries; nose-bleed has many times given him much alarm; the hemorrhage from slight cuts, pin-pricks, scratches, etc., is controlled with difficulty, and a few years ago, while absent-mindedly biting his lips, he caused a slight abrasion from which blood spurted in alarming quantity. No other members of his family are bleeders, so far as known. While urethral hemorrhage may not be rare, I am unable to find in the works at hand any reference to bleeding similar to that which occurred in this patient.

## CLINICAL LECTURE.

### THE MEDICO-LEGAL ASPECT OF APHASIA.

BY DR. C. K. MILLS.

*A Clinical Lecture delivered at the Philadelphia Hospital.*

REPORTED BY M. V. BALL.

APHASIA has an important place in legal medicine not only from the fact that it is often combined with insanity, but because questions often arise as to the responsibility of the afflicted person or his testamentary capacity. In every case we must find out how far the patient is able to speak, how far he can make himself understood by speech, and how far he can explain himself by means of pantomime.

By pantomime we mean the use of signs for definite purposes, and it may be present with speech, and on the other hand it may be lacking, while speech is preserved. In bringing these patients before you, illustrating as they do various kinds of aphasia, I will dwell mainly on the medico-legal aspect of the subject.

In CASE I. we have an old hemiplegic woman, who answers every question with a single recurring utterance, namely, "la-la," she is paralyzed on the right side, and

has been in the hospital many years; she understands everything that is spoken to her; she puts out her tongue when told. She plainly evinces her disgust by pantomime, when asked if she wants medicine, and yet the full extent of her vocabulary is "la-la."

CASE II. is a man who replies to all questions with the two words, "any one." Here we see that the man likewise understands all that is spoken to him, but has only these two words to make his wants known.

CASE III. says "no" to all questions, even when he means yes. Occasionally he utters an oath, but this utterance is involuntary and he is not responsible for it.

CASE IV. is a man who cannot talk at all; when questioned he shakes his head. He understands what is said, but is unable to utter a syllable, although able to make his wants known in writing. There is no paralysis present, but as his trouble came on suddenly, and as the result of an accident, there was probably a hemorrhage.

CASE V. is a woman, who, when asked her name, answered promptly, "B. Doyle;" when asked whether it was Bridget, she made some incoherent remark; when shown a penknife and told to name it, she replied that "she knew what it was, but could not tell the name of it;" when shown a key, she said it was for hiding things; a watch was called "money;" she said "she was going to say hammer, but she knew that is not right." After some effort she exclaims, "gold," and when asked if it is not a watch, she says, "yes, a hatchet." She is able to name correctly her hand and foot. This woman, like the others, is able to understand everything that is told her and has an extensive vocabulary, but certain words she cannot speak. She has a form of verbal amnesia. She is neither word-blind nor mind-blind, she recognizes objects and their uses; she can even recall the names of such familiar things as her hands and feet, but many other concrete nouns she cannot name.

CASE VI. is a young woman who has been paralyzed for one and a half years. After the attack she had slight trouble with speech; she is an example of left hemiplegia. As a rule, only right-sided hemiplegia is accompanied by persistent aphasia, but when the person is left-handed, aphasia may be present in left hemiplegics.

CASE VII. is a man who, when asked a question, responds, but in a very imperfect manner. He is neither demented nor word-deaf; he is able to make known his wants, but there is a paralytic condition of the muscles of articulation. The man has the power to propositionize, that is, to construct sentences properly and speak them.

CASE VIII., an old man who is unable to stand without support, a complete hemiplegic, when asked his age, showed with his fingers that he was forty, but he looks at least sixty. He can only make a moaning sound, and, although understanding what is told him, is deficient in pantomime and resembles a demented person in his appearance.

CASE IX. is a woman with verbal incoherency; she will start out well and then will come a word or phrase which has no connection with what has gone before it. Her language is a form of jargon. The patient is able to understand all that is spoken to her, and has a large vocabulary, but the speech is broken up by putting in words that do not fit; her reading is much like her



speech. Some patients read rapidly and fluently what is a jargon to others, the person reading understanding all the time what he is reading, but may not be understood by his hearers.

Having shown you these patients we will now test them in a medico-legal way as to their responsibility. The cases in which aphasics become involved are more often civil than criminal.

Aphasia, like deafness, tends to make a person emotional, impatient, quick to anger, and so occasionally crimes of violence may be committed in moments of passion that are clearly attributable to the infirmity. Insanity itself may be present. The insane wards of a hospital contain some aphasics, and so the same questions that apply to the insane in any court case may arise in connection with this disease. In examining an aphasic the question to be answered is not, is an *aphasic* responsible, but is this or that *aphasic* responsible. Hughlings Jackson illustrates the matter well when he says that the question at issue is not whether a piece of string will reach across a floor, but if this or that piece will.

One of the questions that may arise in a civil case is the one in reference to testamentary capacity, Can the aphasic make a will? Can he be held responsible for a note or any other piece of writing to which he has affixed his signature or mark?

Some years ago I was called to see a man who had been stricken with an attack of apoplexy, and who was living with a woman not his wife; after the attack he married the woman, and then dying left his money to her. An attempt was made to set aside the will on the ground that the man, being an aphasic, was not responsible. I could testify that he was able to understand everything I said to him when I saw him, and the will was allowed to stand.

Starr gives the following list of questions useful in examining cases of aphasia:

1. Has the patient the power to recall the spoken or written names of objects seen, heard, tasted, or touched?
2. Has the patient the power to understand speech and musical sounds?
3. Has the patient the power to understand written or printed words?
4. If he speaks voluntarily, does he talk clearly, does he mispronounce, does he misplace, or talk jargon?
5. Has he power to repeat a word after hearing it?
6. Is he able to read aloud, and, if so, does he understand what he reads?
7. Has he the power to write voluntarily, and can he read what is written?
8. Has he the power to write at dictation?
9. Has he the power to copy?
10. Has he the power to recognize the use of objects seen, heard, felt, or tasted?

The following is a subdivision: Has the patient the power to communicate his thoughts by pantomime? The power to understand signs, as well as expressing them, may be lost in some cases.

Let us test Case III. You remember his vocabulary consists of one word, "no." I hold a pen before him, and ask him if he knows what it is; he has not the power to name the object. When told to put out his tongue he does so, therefore he understands what I tell him; but when I ask him his age, he continues to put

out his tongue. This is probably mere confusion from the examination, though it should be noted, as it may have some bearing in the matter. I ask him if the word on this paper is New York; he shakes his head in a negative manner. Is it Philadelphia? He moves his head in assent, it being correct. So we see he has the power to understand printed words. Further testing shows that he also understands writing. He can talk voluntarily only to a very limited extent, and only in monosyllables, as "no" and "no, sir." He cannot repeat words or letters, but, strange to say, he can count up to sixteen without any effort. Sometimes he talks a little jargon. This man knows what he wants to say, and understands what is spoken to him, but he will say "no" when he means "yes," and he is easily confused. He will not write to-day, although he has written a word or two on another occasion. He can make his wants known only with great difficulty, and therefore might be understood as meaning one thing when he meant another. The man has a motor aphasia, probably due to a lesion in and around Broca's convolution, with destruction of tissue in the neighborhood. He has a motor aphasia, a motor agraphia, and a loss of pantomime almost equal to his loss of speech, becoming very much confused when he attempts to use his head or hands except in counting.

Testing Case VII, we find that he understands what is said; that he can read written and printed words; that he has the power of voluntary speech; that he can repeat after others; and that he can write and recognize objects. His articulation, however, is very bad; he is not easily confused, and when I ask him to sign this note he does so, but he tells me he would not do it if it meant anything; he is in every way responsible and competent.

Examining Case V, we have a different state of affairs. You remember she understands what is told her, but when I ask her how old she is she replies, "five cents." When I ask her to count *five* on her fingers, she says "three;" therefore she cannot repeat after me, and her pantomime is bad. She knows the use of objects, but mixes up the names. She is not letter-blind—that is, she can voluntarily read individual letters, and she can read her own signature; but she might be cheated because, although she can speak and can understand, yet she cannot make her wants clearly known, for the reason that she may have intended one thing and said another. In getting the mark of this person to an I O U she places it far away from the proper position. A case is on record where a man by pantomime showed how much money he wanted to leave to another, but he made his mark in the body of the will instead of at the end, and the will was not considered legal. It is dangerous to guide the hand of the person, because it might be construed as a form of compulsion, and the document would not hold in the law.

I have thus been able to show you a few of the kind of cases commonly met with, and to indicate the way in which questions of a medico-legal nature may arise. The subject is of interest, and could be more fully treated had we sufficient time at our disposal.

## MEDICAL PROGRESS.

**Multiple Bacterial Infection in Certain Forms of Diphtheria.**—DR. WM. ROYAL STOKES (*Boston Med. and Surg. Journ.*, Dec. 12, 1895), in reporting the bacteriological examination of nine autopsies on cases of diphtheria treated with antitoxin, says: "In eight of the nine cases of uncomplicated diphtheria to which antitoxin had been given the bacteriological examination at the autopsy showed a more or less well-marked invasion of the blood by the pyogenic cocci. In five cases the streptococcus was found in the liver, spleen, kidney, and blood of the heart." The same or other cocci were discovered in one or more of the other organs in the remaining cases, while "in the lungs of all these cases were found the bacillus diphtheriae, streptococci, pneumococci, and the staphylococcus pyogenes aureus, either alone or in various combinations."

The recent demonstration of the comparative frequency of this poly-infection in diphtheria is a matter of very considerable interest. Barbier and others, basing their conclusions upon the bacterial examinations of the throats alone, together with clinical observations, were able to point out the existence of two distinct forms of diphtheria as early as 1891; one the simple infection by the bacillus diphtheriae, the other a mixed infection with one or more of the pyogenic cocci as well. Two years later the general belief that the bacillus of diphtheria was only to be found in the local lesion was disproven by investigations which demonstrated its presence in the blood and material taken from the various internal organs of individuals dead of diphtheria. And still more recently, Wright and Stokes have been able to discover it present in the lungs of thirty out of thirty-one cases, while the various other internal organs showed it less constantly, but in a considerable per cent. of that number.

So far as statistics of the double or multiple infection have been collected, they indicate that from fifty to seventy per cent. of the diphtheria cases are of this nature, at all events; a clear majority. And since antidiphtheric serum is known to have no specific influence in controlling germs other than the bacillus diphtheriae, we must not expect its full curative effect in these instances, but should be content to obviate the dangers of a secondary infection in any case by an early and thorough administration of the remedy.

**The Etiology of Obstetrical Paralysis.**—In a recent paper upon this rather obscure subject DR. G. L. WALTON, of Boston (*Journ. Ment. and Nerv. Dis.*, November, 1895), offered the following explanation of its causation: That the brachial plexus already being brought up against the clavicle by rotation of the head away from the affected side, which also places the suprascapular nerve upon the stretch, exposes these trunks to excessive bruising and stretching during the separation of the head from the shoulder, that follows rotation in the strait, the shoulders being naturally restrained by the brim of the pelvis at this stage of delivery. Under the head of obstetrical paralysis Dr. Walton did not wish to include any except those occurring with natural labors, *i. e.*, without instruments, or even the use of traction by hands or fingers of the attendant.

Dr. Starr, in discussion, expressed the belief that the prognosis was uniformly favorable, as he had observed no adults with such paralysis. Exclusive of those instances where there is dislocation of the shoulder-joint, Dr. Walton concurred in this opinion, while Drs. Taylor and Leszynsky had observed cases that caused them to doubt if a perfect recovery was the invariable rule.

**A Case of Congenital Aphasia (Aphemia).**—HERZEN (*Revue Médicale de la Suisse Romande*, 1895, No. 11, p. 600) has reported the case of a boy, five years old, otherwise apparently in good physical and mental condition, who was able to speak only a few words. The family history was good, and there had been no difficulty in the labor or in the pregnancy. The child had escaped the usual infectious diseases. When three years old he could pronounce correctly only three or four words, which formed his entire vocabulary. At this time he fell from a table about three feet high, striking upon his head, but not suffering any permanent disturbance. Consciousness was lost, and it was feared that death would result, but recovery finally ensued, without paralysis or convulsion. Subsequently the little patient acquired a few new words, whose number and pronunciation, however, were below those of a child of his age. Examination disclosed a symmetrical head, free from fissure or depression. The organs of phonation were perfectly normal. The child could open its mouth and move its tongue freely; also emit sounds, and articulate several words more or less intelligibly; but it was unable to formulate any phrase whatever. Its hearing and its intelligence were good. There was no trace of paralysis or of atrophy. The child was right-handed. The explanation of the condition present in the case related is referred to a congenital malformation of the speech-centers in both central hemispheres.

**Death under Chloroform.**—DR. MURRAY AYNSLEY (*New Zealand Med. Journ.*, vol. viii, p. 259) reports this unfortunate accident having occurred to a healthy female who was admitted to Christ Church Hospital, May 6, 1895. She gave a good family history, but was a little anæmic and had a slight goitre. For the removal of a ganglion on the back of the left wrist she was placed under chloroform at 9.45 on the following morning, and was well under before the operation was begun by Dr. Nedwill. The excision had been completed and the chloroform suspended, when the patient began to move a little and vomited a little bile-stained mucus. A few seconds later it was noted that she was cyanosed, but still breathing naturally and the lungs expanding. She was inverted, the throat sponged, and the tongue drawn out. The pulse, however, could not be felt. She was replaced on the table, took several gasping breaths, and after a few moments ceased to respire. Nitrite of amyl, ammonia, and strychnine were administered, and artificial respiration kept up for an hour, air entering the lungs freely during this time. For the first half-hour slight and irregular sounds were thought to have been heard over the region of the heart, but none during the latter half of the time. No autopsy was permitted.

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SATURDAY, JANUARY 4, 1896.

## THE MEDICAL NEWS BECOMES A NEW YORK WEEKLY JOURNAL.

WITH this issue THE MEDICAL NEWS removes its home from Philadelphia to New York and passes into the hands of a new editor. No other radical change has been made or is contemplated. The same familiar face will greet its readers every week, bearing its messages of scientific facts, of personal experiences, of recent discoveries, and of medical news. Messrs. Lea Brothers & Company, now of New York and Philadelphia, will continue as its proprietors and publishers. The editorial and publication offices are permanently established in New York. Dr. J. Riddle Goffe becomes the editor, and in so doing desires to express, in behalf of THE NEWS, a warm esteem for the retiring editor—a high appreciation of his unwearied and able services in the past.

THE MEDICAL NEWS, therefore, takes its place as one of the regular weekly medical journals of this city.

To you, our host of contributors and readers in every land, no new introduction is deemed necessary; but rather would we invite you, as tried and loyal friends, to join with us in a cordial house-

warming in the new metropolitan home, where you will always be assured a hearty welcome and the same unwavering support in your efforts to advance the science and the art of medicine.

As an exponent and leader of what is highest and best in medical literature, THE NEWS will continue to advance the standard of hygienic and sanitary science, to voice the latest discoveries in every field of scientific investigation, and advocate all public measures that will redound to the health of communities and the public welfare. Its columns will be always open to the free and candid discussion of all questions pertaining to the advancement of medicine in its widest interpretation—to questions of interest and importance to the profession itself and to personal matters of individual right and justice. It does not represent any individual interest, nor school, nor clique, but aims to be an exponent of the highest and broadest interests of science and the medical profession.

The Science of Medicine is being rapidly revolutionized and rewritten, on what gives promise of being an enduring basis of scientific fact. The veil that has hidden from our view the mystery of diseased processes is being rent in twain, and a flood of sunlight is converting the workers of disease into manufacturers of antidotes against their own destructive powers.

It is the proud boast of the physical sciences that they have chained the great material forces of Nature and trained them to man's service. But the silent, secret microscopical forces working against man himself are the last to yield to his intellectual power. The triumph, however, is the greater and the glory is with us of the medical profession. It is a privilege to be in at the birth of what promises to become the crowning achievement of medical science and an unspeakable boon to humanity.

To test and extend the application of the new therapeutics is the work of the immediate future, demanding the accurate application of exact scientific methods. To the general practitioner is committed the trust, to him the scientific world looks for the account of his stewardship; and it is to him especially that the columns of THE MEDICAL NEWS are cordially opened as the most appropriate place for recording his triumphs, deductions, and conclusions.

Yet, after all, this is but one of many fields in which the physician and surgeon are constantly at work to relieve the sufferings of humanity. THE



MEDICAL NEWS will, as heretofore, be ever on the watch to present to the profession all the discoveries and improvements which may be made in all the departments of the science. It can point to fifty-two years of earnest service rendered to all the highest interests of the medical profession, and it will be the unswerving purpose of the new editors to surpass, if possible, this honorable record by the diligent utilization of the superior advantages of their metropolitan position.

#### THE STATE COMMISSIONER OF LUNACY.

THE Commissioner of Lunacy as an expert was editorially noticed by the *Record* recently, which goes on to say that "attention has been called more than once to the reprehensible conduct of the medical member of the State Commission in going upon the witness-stand for pay. That he has no right to do so in this State cannot be disputed, for his testimony in court, when it is given by him as an 'expert,' may send the prisoner to an asylum or a prison. As the doctor and his associates are bound by law to recommend the discharge of improper subjects from the former, it can be seen how dangerous must be his position if he has given testimony in a particular case." Just so. And see what has happened within less than a month. He took the stand and declared Hannigan insane. Within two weeks, so remarkable was recovery, the Commission was asked to discharge the man. Yet how could it do so in the face of the testimony so recently given. The courts were appealed to.

Judge Barnard refused to order the discharge of the prisoner from the State Hospital, and insisted that the indorsement of the State Lunacy Commission to the certificate of sanity given by the superintendent of the hospital is needed to make Hannigan's discharge legal.

He says that when a man is acquitted of the crime of murder on the ground of insanity, and then committed to an asylum, three processes are needed to secure his discharge—viz., first, the certificate of the superintendent of the asylum; second, the indorsement of the State Lunacy Commission; and, third, an inquiry by a Supreme Court Justice as to the man's sanity. He could not understand, he said, why the Lunacy Commission refused to indorse the certificates of Dr. Pilgrim. He remanded Hannigan back to the asylum.

Immediately after Judge Barnard declined to discharge Hannigan from the hospital his lawyers

went to Newburg. There they found Justice Brown, and renewed their application for a writ of habeas corpus for their client. Judge Brown signed the writ. He was unwilling, however, to hear arguments on the case that day, though the officials of the hospital had taken Hannigan to Newburg immediately.

The Commission was appointed to save the taxpayers of the State, not to furnish means for useless expenditures. The detention of the superintendent, the various keepers and attachés in attendance at court—first in Poughkeepsie, then to Newburg—was a waste of public moneys and a perversion of principles. The Legislature should speedily amend this section, for what was a few days ago only a theory, to-day becomes a burning shame.

#### WHICH DOES IT ADVERTISE?

THE above question is irresistibly suggested by a glance through a bulky pamphlet recently issued in Chicago by the manufacturer of one of the many concentrated foods which glut the market. It is the stale and familiar compound of "original research," reports by the hired chemist of the firm or by similarly "influenced M.D.'s," who usually sign themselves as third or fourth assistants to some distinguished hospital or clinic, with testimonials from various physicians and "professors," deftly interspersed with insinuating and laudatory remarks by the head-salesman. All of which has the impudence to call itself "scientific matter," and claim to be latest views upon the problems of nutrition, "condensed for the benefit of the busy practitioner," who is expected to be duly grateful therefor. And the agents who distribute these actually assume the airs of benefactors and enlighteners of a poor, benighted profession. A very brief inspection of this particular hodge-podge, however, reveals the fact that, like a "double" Uncle Tom's Cabin, it exploits "two Topsyies," and that the burden of its song seems to be divided between "the product" and its "developer," a certain doctor of our own city (to our shame be it said) whose name and titles adorn its columns in reckless profusion, occurring ten times in the first twenty pages. This apotheosis begins in the introductory chapter, where he is hailed as the genius who developed new methods of application . . . of this power" . . . "up to the marvellous scope and efficacy now exhibited by his reports, which make up the marrow of these pages." Not

the marrow merely, but the periosteum also and part of the Haversian systems, for his name appears at the foot of articles, at the head of them, in the middle of case-reports, and even in the ignominious ruck of testimonials from the wilds of Arkansas and the cross-roads of "Injianny." In fact, it seems to be a contest between the Doctor and the food, with the odds in favor of the Doctor; for while he achieves the proud literary feat of mentioning the food by name *eight* times in a single page of "contribution," yet it gets only a plain capital, while his name looms up majestically in double capitals, with its titles trailing behind it like the lurid tail of a comet, clear across the page. This is by no means the first time that a physician has endeavored to waft himself into prominence on the wings of a proprietary remedy, but it is such a glaring and disgusting instance of the offence that it merits special mention. Its very grossness, however, defeats itself, for it is so palpably overdone that it raises the question, Who pays for the advertisement, the manufacturers or the Doctor?

Another amusingly impudent feature of this pamphlet is the insertion of the names of distinguished clinicians, in staring capitals in the middle of pages loaded with resounding praises of the aforementioned food, which names, however, on careful inspection, are found to be simply appended to some trite commonplace as to the value of nutrition, the uses of proteids, etc., with no reference to the food whatever. It reminds one decidedly of the late Artemus Ward's lecture-prospectus, which read somewhat as follows:

"MR. WARD HAS DELIVERED THESE LECTURES BEFORE ALL THE CROWNED HEADS OF EUROPE ever thought of delivering lectures."

#### OUR CHANGE OF HEART.

THE *Medical Record*, in commenting upon our removal to New York, interprets it as evincing "a sudden change of heart." We beg to submit that this is not a sudden change of heart, but simply a change of base.

To hold the affections subordinate to the reason is recognized as a safe rule of conduct, and it is in obedience to this that this Journal, after a careful consideration of all the factors in the situation, finds itself irresistibly drawn to New York. We are far from admitting, however, that the kindly consideration of our esteemed contemporary may

not draw our affections after us, and lead us to experience the realization of the old saying, that where our friends are there will our heart be also.

## ECHOES AND NEWS.

CORNELL girls have successfully withstood two sessions of vivisection without any marked increase in hysterics or nervous diseases. All students at Cornell are required to dissect during a part of their freshman or sophomore year.

THE foundlings of New York hereafter will be sent directly to Bellevue Hospital. It has been learned that under the present rule, whereby such waifs are first taken to Police Headquarters, at least eighty per cent. die of exposure and hunger.

THE pre-trial system, so extensively used by the governments of Germany and France, has been advocated by the chief expert to the New York City District Attorney's office, and its workings are being carefully watched in a series of cases. There will, under the new system, be no convictions of insane men, and fewer sane men will be able to escape on the plea of insanity.

A SPECIAL MEETING OF THE NEW YORK ACADEMY OF MEDICINE was called on the 27th ultimo to consider resolutions of censure for the Commissioners of Charities and Correction in their recent action in placing the appointment of physicians and surgeons to the various hospitals in the hands of the three principal medical colleges, together with the fourth division of Bellevue Hospital.

After a prolonged discussion the resolutions were *not* sustained, the vote standing 47 to 108.

THE danger of blood-poisoning in piercing the ear is not to be ignored because the operation is supposedly not a dangerous one. There is nothing right about this home surgery. The cleanest person, when it comes to a surgical operation, is, without proper scientific laving, medically unclean. A woman takes a needle, any needle, and threads it with any thread. This thread may have been in her work-basket months and months, lying next to other spools of all colors. She would not think of washing her own hands or washing the ear to be pierced. A cork is taken out of some bottle, any bottle, without thought as to what is in the bottle or how long the cork has been exposed to the dust. This cork is placed under the lobe of the ear for the needle to strike against when it comes through. Inflammation and suppuration naturally result.

It is reported that Dr. Cæsar Lombroso has just been convicted in a French court of gross plagiarism, and condemned to pay the man out of whose book he stole the sum of 2500 francs. The plaintiff, M. Crepieux-Jamin, found in *La Grafologia*, a work by Lombroso, published at Milan, passage after passage which were simply translated from a book by M. Jamin, to whom no credit was given, and whose name was not once mentioned by this soi-disant criminologist. He brought suit at Rouen under the International Convention adopted at Berne, in 1844, and won a verdict without difficulty, the evidence being indubitable. A tendency toward plagiarism, we have been told by both Lombroso and Nordau, is a sign

of degeneration. Doubtless it is—degeneration of the conscience.

THERE will be held at Washington, D. C., on February 10, 1896, a competitive examination of candidates for appointment to the position of Assistant Surgeon in the U. S. Marine-Hospital Service. Candidates are required to be not less than twenty-one or over thirty years of age. They must be graduates of a reputable medical college, and furnish testimonials as to character.

Successful candidates, having made the required grade, are appointed in order of merit as vacancies arise during the succeeding year. There is at present one vacancy.

A successful candidate when recommended for appointment is commissioned by the President of the United States as an Assistant Surgeon. After four years of service, and a second examination, he is entitled to promotion to the grade of Passed Assistant Surgeon, and to the rank of Surgeon, according to priority, on the occurrence of vacancies in that grade.

The salary of an Assistant Surgeon is \$1600 per annum, together with furnished quarters, light, and fuel; that of a Passed Assistant Surgeon \$1800 per annum; and that of Surgeon \$2500 per annum. In addition to the above salaries, after five years' service, an additional compensation of ten per cent. of the annual salary for each five years of service is allowed medical officers above the rank of Assistant Surgeons, the maximum rate, however, not to exceed forty per cent.

When an officer is on duty at a station where there are no quarters furnished by the government commutation of quarters is allowed at the rate of \$30 per month for an Assistant Surgeon, \$40 for a Passed Assistant Surgeon, and \$50 for a Surgeon. The successful candidates after receiving appointments are usually ordered to one of the larger stations for training in their duties.

Full information may be obtained by addressing the Surgeon-General of the Marine-Hospital Service, Washington, D. C.

**THE REMEDIES OF ANIMALS.** From the earliest ages animals have been credited with a considerable knowledge of the medical properties of plants. Legund relates that Esculapius cured a patient by using an herb which he had seen a sick goat search for and eat. In the Middle Ages systems of therapeutics (bestiaries) were founded upon reported animal practice, just as to-day the populace confide implicitly in the sovereign virtues of Indian "blood-medicines," and Chinese, negro, or gypsy "roots" or "herbs." A writer in the London *Spectator* gives a most elaborate and interesting list of the remedies reported to be used by animals for either the cure or prevention of disease. Grouse, for instance, during an epidemic of bird-plague, have been known to fly down to the seashore and eat the salt-crystal evaporated upon the rocks. Pheasants scratch up and eat the roots of the wild arum, which are so pungent as to blister the tongue, and also the colchicum-root, presumably as aromatic digestives; at all events pepper and other spices must be added to their food when domesticated. Quite a variety of substances are eaten apparently mainly for their mechanical effect as emetics and purgatives by the carnivora. This is the rationale of the familiar use of grass by dogs and cats, also by lions, tigers, and leop-

ards, and of ashes or dirt by dogs fed largely from dishes or upon cooked foods. Our author also adduces the fondness of ruminants for salt and of birds for grit and gravel as cases in point, but these come distinctly under the head of diet and normal aids to gizzard-digestion. The same sort of objection applies to the great variety of water, dust, and mud-baths given by him, though, so far as the last two are directed against parasites, they may be regarded as remedies.

Indeed, the impression decidedly given by a careful study of the whole list is that the actual amount of really "medical" knowledge possessed by birds and animals is very slight, as would naturally be expected in view of the absence of any form of language adequate to transmit the knowledge of one generation to the next. Disease is such an infrequent and irregular factor in animal welfare, leaves such comparatively slight permanent imprints upon either mind or body when mild, and none at all, of course, when fatal, and is so very seldom inherited, that it is hard to imagine how "remedial" instincts of any sort could well be transmitted, while the amount of therapeutic knowledge directly acquired during the brief lifetime of an individual must be very limited. Speech is absolutely necessary for the transmission of any but the most rudimentary forms of knowledge. In the realm of surgery and external applications birds and animals make a somewhat better showing, because parasites and wounds or other injuries play a much more frequent and constant part in their experience, and hence some rude idea of their treatment can both be acquired by the individual and transmitted so as to be acted upon by natural selection.

And yet even here it seems to be largely a process of using the first application that comes to hand. Nearly all birds and animals use dust-baths or mud-baths of some sort to protect themselves against vermin, and some are said to exercise a choice between different sorts of mineral-laden earths. Sea-birds are said to seek fresh water to bathe in. The dog in particular and carnivora in general cleanse and soften their wounds by licking until a sort of plaster forms over them, composed of saliva, hair, and dust. The elephant blows dust from his trunk over his surface-wounds, or covers them with mud, and even plasters up bullet-wounds with the same materials. He will also cover his sun-scorched back with cool green leaves. Tradition declares that the pig is the original inventor of the mud-bath—which seems tolerably obvious—and that several of the mineral-springs of Europe were discovered by the swine-herds whose pigs resorted to them for the cure of skin eruptions or diseases. The famous waters of Bath are said to have been brought to human notice in this way by the swine of Prince Bladud. Nowadays such things are done by syndicates—which is much better. In fact, animal medicine and surgery are at best extremely primitive and blunted, and most of widespread popular beliefs to the contrary are either superstitions or due to misunderstandings. The fondness of cats for catnip, for instance, is solely due to the similarity of its odor to the feline genital secretions. The mongoose does not depend on an herb to cure him of cobra-bite, but upon his extraordinary agility and skill in avoiding the snake's stroke, and most such "cure" and "antidote" stories have little better foundation.



## SOCIETY PROCEEDINGS.

## NEW YORK ACADEMY OF MEDICINE.

*General Meeting, December 19, 1895.*

JOSEPH D. BRYANT, M.D., PRESIDENT.

## VAGINAL VERSUS ABDOMINAL SECTION IN DISEASES OF THE FEMALE PELVIC ORGANS.

DR. W. M. POLK read a paper with this title. (See page 2.)

## DISCUSSION.

DR. E. W. CUSHING, of Boston, opened the discussion. He said that there could be no longer any doubt in the minds of those who had studied the evolution of vaginal hysterectomy that the resources of our art had been wonderfully increased by the introduction of morcellation of the uterus, and it was very significant that in the face of opposition the method had steadily increased in popularity, until now it numbered among its advocates some of those who at first had most bitterly opposed it. There were still many, however, who believed with an eminent surgeon in this country that vaginal hysterectomy for pus-tubes was "blind, ignorant, and cowardly." The question at the present time was really between total abdominal and total vaginal removal of the uterus and appendages. By splitting the uterus in half the organ could be brought down much further, and by successively dividing these halves it could be made to descend gradually and rotate anteriorly, thus bringing into view any adhesions that might exist. Clamps were applied to the vessels of the broad ligament under the guidance of both sight and touch. By this method of operating the uterus could be safely and quickly extirpated, even when bound down by firm adhesions, and fibroids up to the size of a coconut could be removed with far less shock than by abdominal section. The simplicity of this method and its comparative freedom from danger could hardly be believed by one who had not had the opportunity of seeing it done by an expert. If the tubes are full of pus, they may be opened and washed out without soiling the peritoneal cavity. Want of space between the ischia and a tumor over five inches in diameter are serious contraindications to the vaginal operation, and where there are many adhesions to the intestine one not thoroughly familiar with the vaginal route should not attempt to operate by this method. It was generally accepted, the speaker said, that the vaginal operation was best in the severest cases—those in which there are large purulent accumulations from tubo-ovarian abscesses, or from suppurating hæmatocele where the pus is roofed in by dense adhesions of bowel and omentum. When it is not certain that both appendages are involved the vaginal vault can be opened behind, or, still better, anteriorly, and the question of the removal of the appendages determined by inspection. The advantages of the vaginal operation were diminution of shock, freedom from abdominal wound and scar, and from the liability to hernia.

DR. CUSHING then projected on a screen a large number of photographs taken during a vaginal operation, and exhibiting the various steps in the technique, as well as the facility with which the uterus and associated

tumors could be brought into view and carefully examined.

DR. W. T. LUSK said that it was particularly interesting to hear from Dr. Polk on this subject, as he had been the pioneer in this work in this city. When it had been proposed in Brussels, in 1892, to substitute the vaginal route for the abdominal method in doing much of our work, the speaker said that he had received the suggestion with impatience, but his attention had been called to the method by the great rapidity of convalescence of patients operated upon by the vaginal route, and he had at last become a convert to the vaginal operation. The capabilities of the method had been strikingly demonstrated to him by a personal observation of the work of such surgeons as Péan, Pozzi, Ségond, and Jacobs. Notwithstanding the length of time required for the removal of fibroids by the vaginal route by morcellation, it was worthy of note that the operation had scarcely an appreciable effect on the patient. In cases of double pyosalpinx, in which the uterus was removed first and the tubes afterward, the vaginal method was certainly safer than the abdominal. He had hesitated longest about employing the vaginal route in cases in which it was desired to do conservative surgery on the appendages, and he still thought that the abdominal route was the better for this class of cases except where a free anterior incision was employed. By the latter procedure it was usually possible, if the tubes were not greatly enlarged, to detach the tubes, and bring out first one cornu, then the fundus, then the other cornu, and lastly the tubes. There was no more shock attendant upon this procedure than followed ordinarily an amputation of the cervix. On its merits alone, he would say that the vaginal operation was the coming method, but there was another reason, and that was that the women were beginning to insist that they should be operated upon in this way. In closing, the speaker cautioned those who wished to change to the vaginal method to go slowly, and select for a trial of this method only the simpler cases. He felt sure that these vaginal operations would be followed by much less discomfort to the patient.

DR. J. M. BALDY, of Philadelphia, said that he believed he was almost alone here in opposing the vaginal operation. He had no quarrel with the beauties of the vaginal method, nor did he question many of the advantages and results, but he felt that the two routes had not been compared with sufficient care. He was positive that there was as little shock after the abdominal operation as after the vaginal operation, and also that the peritoneal cavity was opened almost as frequently by the vaginal route. He also contended that it was infinitely more reliable to operate through the abdomen with the patient in the Trendelenburg position than to operate by the vaginal route, because in the former one had the aid of both sight and touch, and was in a much better position to determine whether an operation should proceed further or terminate as an exploratory incision. In comparing the two methods of operating, great stress was laid upon the very slight degree of shock observed after the vaginal operation; but in his experience shock was not a great element in pelvic surgery. To be sure, the pulse often became weak after the operation, but this was usually due to the withdrawal of the ether. Another common argument of the advocates of the

vaginal operation was that hernia was avoided. Hernia after abdominal operations was now comparatively rare and was perfectly amenable to proper and timely treatment; moreover, a number of cases of hernia following vaginal hernia had already been reported. Any surgeon would agree with him that a vaginal hernia was much more difficult to treat than an abdominal hernia. The bright side of the vaginal method had been very ably presented, but nothing had been said about the alarming proportion of fistulae following this operation. Most operators by the vaginal route had included fifteen or twenty cases of fistulae in their lists of these operations, and many of them had spoken of the difficulty of curing them. Sometimes an abdominal operation was demanded for the relief of this serious complication of the vaginal operation. Injury to the ureters was not at all uncommon, and by the vaginal method the operator was ignorant of the existence of the complication. Three times in his own experience he had injured the ureters in abdominal operations and only discovered it just in time to rectify the difficulty.

One of the great objections to the vaginal method was the incompleteness of the operations. He had never seen a vaginal hysterectomy do a complete operation. As an expert operator required nearly twice the time to operate by the vaginal route as by the abdomen, this prolongation of the etherization was a matter for serious consideration. Nor could he accept the statement so persistently made, that convalescence was much quicker after the vaginal operation. The abdominal operator believed that his patient was better off in bed for four weeks after the operation, irrespective of her recovery surgically; the vaginal hysterectomist allowed his patient up as soon as she was surgically well. After considering all these arguments, and duly weighing them, he was free to confess that in his opinion the balance was in favor of the abdominal operation, sentiment not considered.

DR. E. B. CRAGIN said that the first vaginal coeliotomy he had ever seen had been done by Dr. Polk, and the more he saw of vaginal work the better was he pleased with it. All surgeons must have noticed a certain depression of the patient after abdominal operations, and without stopping to consider whether or not this was shock, he would say, further, that all must have noticed also that this depression was not so great after the vaginal operation. He could not agree with Dr. Baldy in excluding from the cases suitable for vaginal operation large pelvic intraperitoneal abscesses. These were exactly the cases in which the vaginal operation showed its superiority.

Since March 2, 1895, he had performed 55 vaginal coeliotomies, of which 42 were for diseased appendages. According to his experience, therefore, about 75 per cent. of cases of diseased appendages were suitable for the vaginal operation, and the remainder for the abdominal operation. He believed that there was more danger of injuring the rectum in the vaginal operation, yet, as Dr. Baldy had said, the ureters were likely to be injured in abdominal operations. He believed that the vaginal operation gave better results, both immediate and remote, and that vaginal hysterectomy was an operation that had a future.

DR. CHARLES P. NOBLE, of Philadelphia, said that the arguments in favor of the vaginal route had been

presented, but everything had been stated in very general terms. He would like to ask Dr. Polk and Dr. Cushing how many vaginal operations they had done, how many deaths they had had, and how many fistulae they had met with.

DR. POLK replied that his mortality had been 3 in 72, and the fistulae 2 in 73.

DR. CUSHING said that he had had about 75 vaginal hysterectomies, with 5 deaths; and of this number there had been 2 urethral fistulae and 1 fistula of the bladder, all of which had been cured. In a recent series of cases there had been 20 vaginal operations, with 1 death. All his operations had been complete.

DR. NOBLE said that in comparing the two methods of operating one should consider the mortality, the morbidity, the sequelae, the mode of convalescence, and the ability to deal with complications. The mortality was very low by both methods, although it was somewhat less by the abdominal method. It depended chiefly upon the operator. The morbidity after abdominal operations was not more than 5 per cent. in his experience. Adhesions occur with both methods. Most operators reported about 10 per cent. of incomplete vaginal operations, which should be contrasted with the small number of infected pedicles in the abdominal method. He thought that there was but little doubt about bowel and bladder fistulae being more frequent after the vaginal operation. His own cases of vaginal hysterectomy had been in hospital as long as the abdominal hysterectomies; in fact, he thought convalescence was more rapid after the abdominal operation. By the abdominal route, in his opinion, it was far easier to cope with complications arising during the operation, and also to control the hemorrhage. The use of clamps to arrest hemorrhage was at best very crude surgery. As he had recently reported 200 cases in which the abdominal wall had been united with buried silkworm-gut sutures for the relief of hernia, and without a single relapse, the argument that the abdominal operation should be avoided because of the frequency with which it was followed by hernia should have but little force.

Where the facilities in a hospital for securing asepsis were poor he would prefer to operate from below. He was prepared to believe that by anterior colpotomy one could remove small fibroids, but for larger tumors he would greatly prefer abdominal section to the vaginal operation with morcellation. He would likewise prefer the abdominal route in dealing with tubal pregnancy, except in the few cases in which there was a suppurating hæmatocele. The operation from below was likely to result in the unnecessary sacrifice of ovaries in this class of cases.

He did not wish it to be understood that he was opposed to all operating through the vagina, but he would reserve this method for cases of large pelvic abscess, and where the women were very fat.

DR. H. J. BOLDT said that his conclusions regarding the comparative advantages of the two methods had been formulated only after a large experience with both abdominal and vaginal operations. The vaginal operation was applicable to tumors of considerable size, provided the neoplasms were movable, to cases of tubal pregnancy before rupture, or after rupture and cessation of hemorrhage, and to fibroids which did not extend more than three or four fingers above the symphysis.

The submucous and interstitial fibroids were most successfully treated in this way. For other fibroids, and for neoplasms in virgins, he considered abdominal hysterectomy preferable. It was quite possible to do a complete operation in nearly every case by patient and careful work. The risk of injuring ureters and bowel was about the same in the two methods. He had never seen a vaginal hernia. While admitting the possibilities of the vaginal method, he felt that a more satisfactory diagnosis could be made by a free abdominal incision.

DR. H. N. VINEBERG said that he was among the first to introduce the operation of vaginal incision, which was the forerunner of vaginal section in conservative surgery. He had reported several cases last March. His experience was entirely opposed to the view that the tubes and ovaries could be resected more satisfactorily by the abdominal route. The vaginal operation was particularly appropriate to these cases, because they were often associated with retroversion, a condition which could be readily relieved at the same time by sewing the uterus to the vaginal wall. He could not see that Alexander's operation offered any special advantages over anterior vaginal fixation.

DR. PAUL F. MUNDÉ said that the discussion thus far was calculated to convey the impression that all the New York surgeons had been converted to the vaginal procedure, which was far from the truth. He had extirpated the uterus per vaginam for cancer 27 times with 24 recoveries, but as he had secured just as good results, and more easily, by the suprapubic route, he would not care to employ the vaginal method in these cases hereafter. There was certainly no more shock following the abdominal section. As was well known, he was not given to operating frequently on fibroids, but out of the 33 abdominal hysterectomies that he had performed for this condition, 4 had died. The abdominal operation was certainly easier than the vaginal. He had long maintained, and in the face of much opposition, that all fluid accumulations were best operated upon through the vagina, and he was glad that this method now had an increasing number of advocates. He would limit the vaginal operation to cases of pelvic abscesses in which the vagina was roomy and the sacs could be drained or enucleated.

DR. E. E. TULL exhibited a specimen to demonstrate the completeness of the vaginal operation. He had done 50 operations of this kind with 2 deaths. These deaths were due to purely accidental causes. He could not understand why some surgeons used so many clamps and ligatures. He had recently removed a tumor weighing ten pounds, and in this operation had used only one clamp and two ligatures.

DR. W. GILL WYLIE said that although he had done about 1500 abdominal sections he had resorted to the vaginal route only 100 times. Out of these 100 vaginal hysterectomies there had been only one fatal case, and he attributed his excellent results largely to the fact that these vaginal operations had been done in a favorable class of cases. The abdominal method was assuredly the one admitting of more general application, and if the great surgeons of France had been as expert in abdominal surgery as the American and German surgeons he was of the opinion that the vaginal method would not have been so strenuously advocated.

DR. POLK, in closing the discussion, said that there

seemed to be a general agreement regarding the greater simplicity of the abdominal route, and although it was a general rule that the easier the operation the better the work done, this proposition did not hold good if in attaining this ease of operation it was necessary to do violence to important structures. The peritoneal cavity was just as likely to be opened in the one method as in the other. When the time consumed in suturing the abdomen was considered, it was evident also that there was no very great difference in the time occupied by the two operations in a given case. He had made no mention of cancer in his paper because he was not decided as to which operation was the better one. He was inclined to think, however, that we were justified now in performing abdominal section, and in adding to the old Freund operation the removal of the broad ligament and of infected glands.

It so happened that those who had participated in this discussion had not grasped what he considered the great underlying principle, viz., that peritonitis usually originates in the lower part of the pelvis in close relation with the vagina, and that by early incision into this structure it was possible, with little or no risk to the patient, to cut short diseased processes and save important structures in the pelvis. Having once adopted this practice of early operative interference by the vaginal route, he felt confident that all the objections that had proved such stumbling-blocks in this discussion would be forever wiped away.

#### NEW YORK NEUROLOGICAL SOCIETY.

*Stated Meeting December 3, 1895.*

EDWARD D. FISHER, M.D., PRESIDENT, IN THE CHAIR.

#### GRAVES'S DISEASE—ŒDEMA OF THE EYELIDS.

DR. J. ARTHUR BOOTH presented a case of Graves's disease with the presence of a rather rare symptom—œdema of the eyelids. On inspection the diagnosis of Graves's disease had been made, but the examination had revealed no exophthalmos. There was, however, slight enlargement of the thyroid and a rapid pulse. The patient, a girl, aged seventeen years, was very much frightened when quite young. She had some convulsions following this incident. About the time of her first menstruation œdema of the eyelids first appeared. She now complained of palpitation of the heart, profuse sweating, headache, and general weakness. This œdema, the speaker said, was not a true œdema, as it did not "pit" on pressure. The movements of the lids were harmonious. On palpation swelling and diffused hardness of the thyroid could be made out. When seen about one month later, *i. e.*, December 2d, there was apparently a slight prominence of one eyeball. Four examinations of the urine had been made, but nothing abnormal discovered.

#### CEREBRO-SPINAL SYPHILIS.

DR. CHRISTIAN HERTER presented a young man, aged twenty-eight years, who gave a history of having had a chancre two years ago, and about one year thereafter developing various cerebral symptoms. The vision was first observed to become diminished in the right eye; then there was ptosis on that side, paralysis



of the third nerve, paralysis of the facial nerve and of both trigeminal nerves. After this he developed weakness in certain muscles of the right arm. There was a history of rheumatism in the parents, and of alcoholism in the patient. About one year ago there was a purulent discharge from the left ear, which lasted for several months. One year ago the right eye was struck by a piece of hoop from a barrel. Shortly afterward he began to complain of double vision, and saliva drivelled from the right angle of the mouth. There had been at no time pain in the hand or forearm. Under the administration of iodide the patient had regained some control of the movement of the eye-muscles and right eyelid. The physical examination, on November 26, 1895, showed the man to be small and fairly nourished, with lateral curvature of the spine, and considerable deformity of the thorax. There was slight ptosis on the right side. The right internal rectus was extremely weak, and there was paresis of the superior and inferior recti. There was sufficient power in the internal rectus to maintain binocular vision, but not sufficient to preserve convergence. The reaction to accommodation was greatly impaired. R. V. was 20/50, and L. V. 20/40. Both optic disks were found to be distinctly paler than normal, and the vessels slightly narrowed. Near the right disk were two patches of slight choroidal atrophy. All the movements of the face were well performed, and there was no drivelling of saliva. Reaction of the facial muscles to faradism was well preserved. The temperature-sense and tactile-sense presented fairly well-defined areas. Sensation was preserved over the eyelids, and was only moderately impaired over the nose. Near the lips sensations of pain and touch were slightly impaired. The uvula deviated to the left. The sense of taste did not seem to be distinctly impaired. There was some loss of power in both arms, but this was more marked on the right side. The flexors of the right wrist were weak, and those of the fingers were wholly paralyzed. The power of the pronators and supinators was normal. All the paretic and paralyzed muscles were wasted. All the paralyzed muscles showed the reaction of degeneration to a greater or less degree. The ulnar area of the right hand and lower two-thirds of the forearm showed loss of sensibility to pain, temperature, and touch. In the left hand and forearms there was a moderate loss of power in the flexors of the fingers. There was no wasting of the left forearm or any change in sensibility or electrical reaction. In both arms there was slight and rather coarse tremor when the arms were extended. There was no loss of power in the legs, and sensibility was not impaired. Both knee-jerks were absent, but the plantar and cremasteric reflexes were present. There was considerable oscillation on standing with the feet together and the eyes closed. The patient urinated without straining. There was frequent pain in the right hypogastric region, but no "girdle" pain. There had evidently been marked improvement during the past month under the use of iodide. The conditions present in this patient were undoubtedly due to the lesions of cerebro-spinal syphilis. The fifth nerve had been more damaged than the others.

The speaker said that the two points upon which he desired further information were: (1) The exact location of the lesions at the base; and (2) as to whether or not the patient has locomotor ataxia.

DR. W. M. LESZYNSKY said that he recalled having seen a man, aged about fifty-eight years, with very marked exophthalmos and goitre, associated with marked oedema of the eyelids. This oedema, however, had been absent in one eyelid for a time, and it had gradually disappeared.

DR. B. SACHS said that within the last few years he had seen upward of thirty cases of Basedow's disease, and yet he had never observed such oedema in any of these cases.

DR. J. ARTHUR BOOTH said that he had been unable to find any mention of more than one case of the kind in English literature. It was interesting that no exophthalmos had been noticed until a few weeks ago. It had been suggested that the oedema was due to paralysis of the orbicularis.

DR. SACHS said that he agreed to the diagnosis of cerebro-spinal syphilis in Dr. Herter's case, but would prefer to have it called *multiple* cerebro-spinal syphilis. The involvement of a large number of cranial nerves and imperfect involvement of some of these nerves were especially characteristic features. He had made the diagnosis of cerebro-spinal syphilis several years ago in a case in which there had been complete trophic paralysis of the upper and lower extremities, with ptosis. One critic had looked upon this case as one of neuritis rather than of central disturbance. This view he did not accept, for we had only to suppose that the specific meningitis had extended along the ventral surface of the cord instead of laterally to explain the symptoms. The fact that there had been improvement in some of the symptoms under the use of iodide was, of course, very significant. In his opinion there was no one symptom of greater value than the complete immobility of the pupil to accommodation and light, or the equal impairment of both of these functions. This was very different from the Argyll-Robertson pupil. If in addition to this there was a multiplicity of lesions, the probability of syphilis was very strong. He would not think of making the diagnosis of tabes in this case, because there was absence of the Argyll-Robertson pupil, little or no pain, and no involvement of the bladder.

DR. HIRSCH said that he did not think we could exclude general paresis of syphilitic character. The expression of the face, the tremor, and slight deviation of the tongue, all pointed toward this condition, and the diagnosis could not be made without further knowledge of the psychical symptoms.

DR. HERTER said that from his short acquaintance with the patient he felt that the psychical symptoms usually observed in general paresis were not present. His mental condition and memory were quite good, and his slight imperfection in articulation seemed to be due to an imperfect co-ordination of the lower speech-mechanism. The expression of the face appeared to be due to the ptosis.

THE PRESIDENT said that he would certainly agree with the diagnosis of cerebro-spinal syphilis, and also regarding the points of localization at the base of the brain.

DR. IRA VAN GIESON said that he wished to indorse the term "multiple" cerebro-spinal syphilis from a pathological standpoint. Syphilis of the nervous system should be considered in three forms: (1) The multiple variety appearing in the form of plaques; (2) the form

in which there were discrete gummata; and (3) the form in which there were less tangible lesions of the blood-vessels and interference with the nutrition of the blood-vessels.

DR. SACHS said that through recent researches the endarteritis of the spinal cord had been very definitely established. The specific endarteritis of the cerebral vessels had been recognized for a long time, but more recently it had been very definitely established in some of the cases of spinal syphilis that there was a specific endarteritis of the vessels of the spinal cord with areas of softening in the cord. The speaker said that a few years ago he had been inclined to consider these cases as examples of meningeal infiltration, extending in gradually through the entire cross-section of the cord.

THE PRESIDENT said that most of the symptoms of general paresis were of later origin than those present in the case under discussion. This patient had already shown improvement, therefore the symptoms must be due to specific infiltration at the base of the brain, and also possibly to softening in the cord from an endarteritis—a condition shown to exist many years ago. This was essentially different from the chronic condition present in general paresis.

DR. A. WIENER presented a

#### REPORT UPON A CASE OF PROGRESSIVE MUSCULAR DYSTROPHY,

with the idea of showing that such a case could be improved by treatment. From a review of the literature, he said that it was apparent that the tendency now was to bring the disease formerly divided into spinal and myopathic forms under one head. The patient to be presented this evening, he said, had been exhibited two years ago before this Society. At that time he was twenty years old, and had been perfectly healthy up to May, 1892, and had not experienced the slightest difficulty in performing any muscular movement. The first indication of difficulty was in May, 1892, when he began to suffer from vague pains in the region of the spleen and liver on considerable muscular exertion. Shortly after this, difficulty in going up stairs and walking was observed, and soon atrophy of the lower extremities and back followed. Finally, the muscles of the neck and face became involved. The patient denied alcoholism or syphilis, and stated that his health had been excellent. He had noticed while engaged in athletic sports that the muscles of the upper extremities quickly became fatigued. In 1893 there was no distinct abnormality about the formation of the skull. His general appearance was that of a person very much emaciated, and there was great difficulty in walking and lifting the limbs. On attempting to stand upright he exhibited a marked lordosis. When lying down it was impossible for him to turn over. The muscles were soft and covered with redundant skin. No vasomotor or trophic disturbances were discovered. The deep reflexes were absent on both sides. The spinal column was in no way tender on percussion. Examination of the muscles showed a marked paresis. The muscles of the forearm and hand appeared normal. Mechanical excitability was very much diminished. Electrical examination gave quantitative changes, but no reaction of degeneration. The abdominal muscles were only slightly affected. The orbicularis oris and palpebrarum were the ones chiefly

affected about the face. The deltoid muscle showed simple atrophy of the muscular fibres, with cell-infiltration in the muscle and between the fibres. No hypertrophy of the fibres could be found, and there was no evidence of fatty deposit. The small bloodvessels were filled with blood, and the walls with round cells. The lack of all sensory disturbances left no doubt that this was a case of the myopathic type. No improvement was noticed under the usual tonics and electrical treatment, so it was decided to try the effect on physical culture carried on daily to the point of exhaustion. From half an hour to one hour was devoted to exercises with dumb-bells, Indian clubs, and the use of a health-lift machine. There was evidence of a very marked improvement in every way. Quite lately he had been able to ride forty miles in one day on a bicycle. Some of the muscles still showed atrophy. The improvement was especially marked in the muscular movements and in the partial return of the contour of the parts. The speaker said he did not think such treatment would be efficacious in cases developing in infancy, but where there had been a good development prior to the appearance of the disease this plan of treatment offered a good prospect of success.

DR. G. M. HAMMOND said that the heart-symptoms in this man were very much like those seen in individuals who had received too much physical exercise at a time when the heart was feeble. This man's heart was dilated and hypertrophied, and it was possible that this was due to a loss of muscular tissue as a part of his disease. He asked if Dr. Wiener thought the arrest of the atrophy might not have been spontaneous and independent of the physical exercise. He had himself seen one or two less extensive cases of dystrophy in which the atrophy was recovered from without any treatment. In one of these cases the atrophy was limited to the muscles of the thumb in both hands.

DR. C. L. DANA said that he thought there was a class of cases of progressive muscular dystrophy brought on by excessive muscular work when the person was immature. This form of dystrophy seemed to him to have a different course from the ordinary types of dystrophies. He had seen cases in which he believed the lesion was in the muscles, and in which the course and clinical symptoms were those of dystrophies occurring in acrobats and gymnasts. In these cases the symptoms usually progressed steadily up to a certain point, and then there was an arrest of the process, and sometimes a very decided improvement. This clinical distinction should be borne in mind in estimating the value of the treatment pursued in this case. He doubted very much if such treatment would have much effect on the more usual form of atrophies. In the cases to which he had referred the upper arm, shoulder, and back were usually affected.

DR. B. SACHS said that the case seemed to him of great importance. He was perfectly familiar with the class of cases referred to by the last speaker—the localized atrophies and those due to excessive muscular exercise. The case under discussion, however, did not belong to this category. When first presented to the Society, two years ago, the involvement of the facial muscles was a prominent feature, and the improvement observed had been in the muscles other than the facial ones. There was, of course, room for doubt as to the

value of this particular treatment, yet it should be remembered that no improvement had been observed under other methods, and yet was prompt and decided under physical exercise systematically carried out. The original diagnosis of progressive muscular dystrophy was without doubt correct, and the result of treatment was certainly unique.

DR. JOSEPH COLLINS said that where the proton was diseased it should be evident that no amount of mechanical treatment would be of service, but if the form of progressive muscular atrophy were acquired, then treatment, including exercise, should be of some advantage. He thought, therefore, the case was very instructive. It was begging the question to infer that the improvement was independent of the treatment. He believed this to be a case of progressive muscular dystrophy of the acquired type, no evidence having been brought forward to show that it was heredity, and that the improvement was due to the treatment.

DR. G. M. HAMMOND said that the man had been an athlete and a runner, and yet had developed the muscular dystrophy; hence he could not understand why if the muscular atrophy had developed during exercise, it should be arrested and improved by a resumption of systematic exercises.

DR. C. HERTER said that the case was evidently one of the familiar form of progressive muscular dystrophy, and he felt that the systematic exercise must have had a beneficial effect in bringing about this change. One should not, however, draw too positive conclusions from one or two cases. The case was a most interesting example of what could be done by modifying favorably the nutrition of a part.

The PRESIDENT said that as far as the distribution of the dystrophy was concerned we certainly found cases in which it was exactly similar, and yet we could not trace the exact etiological factor. Where the hereditary element was not present it was possible that there was a better chance for improvement under treatment. He thought that we were warranted in trying systematic physical exercise, at least in cases in which the hereditary factor was not especially prominent.

DR. JOSEPH COLLINS presented a pathological specimen of

#### TUMOR OF THE MEDULLA,

with the following history: S. J. J., aged twenty-eight years, denied syphilis, and had been extremely temperate. The first symptom, numbness in the fingers of the left hand, was observed eight months ago. This gradually spread up the arm, and later on a similar feeling was noticed in the left lower extremity. About five months ago he became so unsteady that he had to give up his work as a bricklayer, but continued working in a factory till two months ago. About three weeks ago he observed a "stiff feeling" in the left side of the head, and the left upper and lower extremities felt unwieldy. On November 22d, when first seen by the speaker, at the request of Dr. Kelly, the head was fixed and slightly drawn to the left. There was no real stiffness of the head, and no abnormality or tenderness. There was no ocular paralysis; the pupils responded to light and accommodation. The fundus was found quite normal. Vision and color-perception were normal. The senses of smell and taste were normal. There was no

unsteadiness of articulation. The knee-jerks were both exaggerated, particularly on the left side, and there was left-side ankle-clonus. The triceps reflex was exaggerated on the left side. The left hand was decidedly ataxic. The patient could walk, and could move the upper extremity in every direction. There was a remarkable diminution of the pain-sense all over the body, including the mucous membranes. Tactile sensation appeared to be unimpaired. Temperature-sense was exquisitely preserved. The patient talked rationally, and the psychical sphere was intact. Examination of the urine showed albumin, but no sugar. The pulse was rapid, the respirations accelerated, and the temperature 102° F. The opinion was expressed that the intracranial lesion could not be satisfactorily localized, but that there was probably a new formation within the brain, subcortically involving the pyramidal projection on the right side. Three days later the patient was seen again, and was found much worse. He was quite somnolent, and the reflexes had become quite sluggish. There was already marked pulmonary edema. An exploratory opening was made by Dr. J. E. Kelly, the surgeon in attendance, just behind the fissure of Rolando. A hollow needle introduced into the brain in various directions found no unusual collection of fluid. On the second day after the operation his temperature rose to 105° F., although there was no evidence of sepsis in the wound. He died December 1st. It was found on autopsy that a great part of the medulla had been destroyed by the tumor, leaving only a mere shell. The remarkable feature of the case was that the man appeared to be well in every respect up to a short time before his death, and yet nearly all of his medulla was gone.

## REVIEWS.

STUDENTS' AID IN OPHTHALMOLOGY. By GERTRUDE A. WALKER, A.B., M.D. 40 illustrations and colored plate. Philadelphia: P. Blakiston, Son & Co., 1895.

WE think that the excellences of this little work—and they are not few—hardly justify its existence or counterbalance its deficiencies. It is too small and scrappy to serve as a hand-book or guide for any student desiring thoroughness, and its obligations to a very limited circle of teachers, coupled with a decided myopia or limitation of the field of vision as to others, is too evident. What can be said of a text-book that conveniently avoids the whole subject of the treatment of heterophoria with these words: "Various forms of nervous disturbance can be traced to faulty muscular power, and complete relief from headache and symptoms of eye-strain is often not obtained until appropriately placed prisms are combined with the lenses which correct the patient's focal error?"

SPECTACLES AND EYEGLASSES. By R. J. PHILLIPS, M.D. Second edition, revised. Philadelphia: P. Blakiston, Son & Co., 1895.

WE are glad to see that a second edition of Dr. Phillips' excellent little manual has been called for by the profession.